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Patient Suicide - Designing a Supervisor's Guide for an Occupational Hazard

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Abstract

This dissertation presents a plan for the design, implementation, and evaluation of an educational programme that will assist supervisors in supporting a trainee following the death of a patient by suicide. The dissertation presents evidence from the literature on the impact the death of a patient by suicide can have on a clinician, both personally and professionally. The focus of the literature review is on the particular vulnerability of trainees in psychiatry to those effects, and on educational programmes researched to prepare trainees to cope. The dissertation describes the suitability of postgraduate training of psychiatrists in Ireland, conducted by the College of Psychiatrists of Ireland, for the implementation of a one hour guided educational supervision session. The guide will benefit a trainee by preparing them for the challenges faced in the aftermath of a patient suicide, and benefit their supervisor by proposing a schedule for support. The Senior and Swailes organisational development model is used to plan the development of a guide. Kirkpatrick's four level evaluation and Stake's responsive evaluation models are used as frameworks for evaluation of the guide.

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Chapter 1 – Introduction

1.1 Introduction

This chapter introduces and provides background to my project, development of an educational programme entitled “Patient Suicide – Designing a Supervisor’s Guide for an Occupational Hazard”. In this chapter I will describe the organisational context in which I plan to pilot, refine, and finally implement the programme. I will present in brief the rationale for taking this project on, with a more in depth examination to come in chapter two. I will name the aim and objectives of this project, and finish the chapter by exploring my role as a change agent for this project.

1.2 Organisational Context

Postgraduate specialist training of psychiatrists in Ireland is conducted by the College of Psychiatrists of Ireland (CPsychI), over two distinct periods of training, of four and three years duration respectively. Trainees are supervised in their clinical placements by a consultant psychiatrist. One of the key components of the curriculum at both levels is a requirement that trainees receive one hour educational supervision with their consultant supervisor per week ("Curriculum for", 2014). A trainee’s progress in gaining competencies can be aided and monitored in supervision, generally the content of the weekly sessions are not fixed or prescribed, how they are utilised is left at the discretion of both trainee and supervisor.

CPsychI, in a statement of its goals, say they hope:

> "to learn from other organisations both in Ireland and abroad with the broader aim of promoting good mental health and mental ill health practice for all those involved in the mental health services both service users and care professionals alike."
>
> ("Our Goals," 2015)

The structure of postgraduate training as well as the ethos of the organisation are ideally suited to the development and study of my proposed educational programme. The guide to a supervision session I will detail in this dissertation is intended to assist and prompt both supervisor and trainee to consider and understand the potential impacts of a patient suicide. The guide will also aim to provide tools for supervisors, which would assist them in debriefing their trainee, and helping that trainee cope effectively should a suicide occur.

1.3 Rationale

A report on the year 2011 shows that 458 men and 96 women had deaths recorded as suicide in Ireland that year ("CSO statistical release", 2014), a figure which is likely to be an under-representation of the true number (Corcoran & Arensman, 2010). This represents the highest figure recorded since the act of suicide was decriminalised in the Republic of Ireland in 1993 and recording began in earnest, and is part of an ever rising rate of suicide over the last 20 years. Murphy *et al.* (2015) describe how rising trends during that period has led to implementation of national policies and programmes aimed at preventing and addressing suicide. One such policy in Ireland is Reach Out (2005), which contains recommendations for action in a number of areas including provision of support to those bereaved following a suicide. A key recommendation of the report is

that counselling should be available to those affected, and that counsellors in this field require specific training and skills.

More than nine out of ten suicide victims will have been in contact with their family doctor in the year before their death (Pearson *et al.*, 2009). Those with diagnoses of mental illnesses are more likely to have seen a psychiatrist in the period before their death. Windfuhr and Kapur (2011) report that 25% of people in the UK who died by suicide have accessed a mental health service in the year prior to their death. In Northern Ireland almost 20% will have accessed any service in the week before death, and more than 30% will have attended a specialist mental health service in the year before death (O'Neill, Corry, Murphy, Brady, & Bunting, 2014).

In summary, suicide rates are increasing in Ireland, conservative figures for 2011 put the figure at over 650 individuals per year. People experience intense grief in the aftermath, and specialist counselling is recommended. By considering data from comparable jurisdictions, it is likely that between 150 and 200 of those individuals will have been in contact with a mental health service anywhere from days up to a year before their death.

At present, if a patient of a mental health service commits suicide, the response of the service is usually to focus on reviewing the circumstances of the suicide. This aims to

identify in what ways the patient may have been better served, to identify areas of risk, and to improve the service provided to the community. The structure of reviews may be dictated or led by local policies. Rarely, if ever, do these policies or review processes take into consideration the impact on the service, or on individuals within a mental health team. Inquests can appear adversarial and imply a failing has occurred at a system or individual level. The natural tendency may be to question one's own role, asking whether more could have been done to prevent a tragic outcome.

My personal experience is merely anecdotal, but it has been powerful enough to lead me to believe there is a problem in how the issue is handled. I can speak briefly of three personal experiences. During the first year of my training, the suicide of a patient of mine was not relayed to me by my clinical supervisor, and I learned of the death of this patient by chance. I was left to work out how to cope with this unexpected and distressing news without guidance from my supervisor. In the second example, a patient of my supervisor died. The impact of that death was not discussed within the team, but we noted how my supervisor changed their usual clinical practice in a markedly defensive way. Finally, a supervisor told me in passing, on the telephone, that a patient of mine had died, and set a time aside for us to examine the file and discuss the case together. While I felt this approach was good, if not the mode of delivery of the bad news, it transpired my supervisor was mistaken, and I had never seen the patient. Looking back I would say none of my three personal experiences were handled in a way that inspired confidence in my supervisor, and the individually adopted approaches

varied widely. As a trainee, I do not believe I have learned by example how I should go about supporting a trainee of my own in the future.

My anecdotal experience is not unique. In a UK study (Dewar, 2000), the value trainees placed on the support received from consultants varied widely. While 39% said their support was very helpful, six percent suggested their consultant had been very unhelpful. Perhaps this is due to the concurrent distress of the consultant, who does not wish to discuss the loss. One consultant confided in this writer that they and their colleagues feel lost and helpless when it came to counselling and supporting a trainee through the difficult aftermath of a patient suicide.

In chapter two I will present literature that shows how personally distressing experiencing a suicide can be for a psychiatrist in training, and how the experience can impact on professional practice. Several studies on the impact of patient suicide conclude that education programmes for trainees are required, (Alexander, Klein, Gray, Dewar, & Eagles, 2000; Cryan, Kelly, & McCaffrey, 1995; Foley & Kelly, 2007; Landers, O'Brien, & Phelan, 2010; Ruskin, Sakinofsky, Bagby, Dickens, & Sousa, 2004). "Reach Out" (2005), the HSE policy document discussed above, points out that counsellors dealing with families affected by suicide need specialist training. It is my belief that psychiatrists, in their roles as supervisors and mentors to trainees, also require specialist training.

1.4 Aim and Objectives

The timeline that would be required to design an educational program, implement it and evaluate its impact is longer than the time available within the confines of this dissertation. The aim of this dissertation therefore is confined to planning the design of a programme, along with a framework for evaluating its impact.

1.4.1 Aim

To plan the design, implementation and evaluation of an educational programme.

1.4.2 Objectives

- To complete a literature review that will provide an evidence base from which the programme content can be drawn.
- To plan the design and implementation of the programme using an organisational development model.
- To plan a framework for evaluating the programme following implementation.

Beyond the lifetime of this project I hope to proceed with the plan and disseminate the findings, ultimately benefitting trainees, supervisors and the community. Should the programme prove itself valuable in the setting of postgraduate specialist training in psychiatry, adaptations could be designed for other medical disciplines and allied health professionals.

1.5 My role in the organisation and project

I am a member of the College of Psychiatrists of Ireland, about to enter on the Higher Specialist Training scheme. My day to day clinical roles are in separate organisations,

within the span of this degree I have worked with four different organisations. As such, I have little day to day contact with the CPsychI. In chapter 3 I will discuss the difficulties and challenges involved in planning and implementing an organisational development project in an organisation within which I have little power or influence. I will discuss the leadership skills required to bring about a change from the status quo, including creating a vision and a rationale for change, and obtaining 'buy-in' from key stakeholders essential to generating momentum and ensuring success.

Key to the design of any new educational intervention is a mechanism for evaluating its impact. I will plan to provide evidence that the programme can impact meaningfully, and I will describe my plan for doing this in chapter 4. My concluding chapter will take a broad look at the entire planning process, I will draw on my experiences to identify what went well, what could have been improved, and what I have learned about bringing about change in an organisation.

1.6 Summary

This introduction provided background and context to my project, a plan for the development of an educational programme entitled "Patient Suicide – Designing a Supervisor's Guide for an Occupational Hazard". I described why I believe this project has merit, and will discuss the literature that supports that belief in the next chapter. I named the aim and objectives of this project, summarised my role as a change agent, and finished by signposting the content of the chapters to come.

Chapter 2 – Literature Review

2.1 Introduction

This chapter presents the evidence base from which I plan design and implement an educational programme, a guide for supervisors to use in a supervision session with their trainee. I will outline the search strategy employed and highlight the areas I have drawn literature from. The chapter is divided along thematic lines. I will use a seminal and widely referenced paper from 1965 to link the themes, and to summarise and draw conclusions on the evidence provided.

Robert E. Litman, in his role as chief psychiatrist at the Suicide Prevention Centre, California, was tasked with carrying out “psychological autopsy” following a death by suicide. In cases where the deceased had been seeing a psychiatrist or clinical psychologist, Litman conducted interviews with these therapists. His observational study was among the first of its kind (1965). Litman summarised the variety of experiences described to him, which he divided into personal (affective) and professional (competence) reactions. He also made recommendations for therapists based on various coping strategies employed by the subjects of his study.

In the more than half century that has elapsed since Litman’s study, many others have examined the impact of patient suicide on clinicians, and the variety of coping strategies employed. More recently some have attempted to provide templates to guide therapists

and their trainees. In this chapter we will see that while a great deal of time has elapsed and society greatly changed since Litman's paper, the human condition has remained a constant, and his original observations remain as relevant as ever.

2.2 Search Strategy

For this review, searches were conducted on several databases: ERIC, PubMed, Google Scholar, Web of Science and CINAHL. The PubMed search strategy was to search for the following MeSH terms; "suicide", "education", "internship and residency", "adaptation, psychological". Initial searches confined to the last five and ten years of publications yielded limited results, so the time searched was increased to fifteen years. The search strategy outlined was modified slightly for each of the databases utilised. These searches provided more than half of the articles eventually included in this review. They include a mixture of surveys, programme descriptions, and a systematic review. As only English language papers were included in the search the papers tended to come from the US, Australia, and Europe. They are published in academic journals from various disciplines including nursing and psychology, but primarily medical and especially psychiatric. The remainder of the articles included in my review are drawn from reference lists of articles from the database searches. These articles include narrative reviews and editorials.

The total number of papers included in the review is 23. I will present the literature thematically, beginning with the personal and then professional impact on clinicians. I

will then present findings specific to trainees, and discuss what makes trainees an important group on which to focus special attention. Next I will summarise the roles and responsibilities of the psychiatrist in the aftermath of a patient's suicide, following which I will describe what types of support aided clinicians in coping with the suicide of a patient. I lastly present the findings of a number of interventions trialled which aimed to prevent emotional and professional fallout.

2.3 Personal impact

Litman noted that professionals treating depressed or suicidal patients are often expected to be able to think philosophically or abstractly about a patient's death, thus supposedly protecting themselves from painful emotions. What he observed from his interviews was that this abstraction often did occur when thinking about the professional aspects of a case, but quite separate and distinct from the professional response was a personal experience, and in this experience

> "therapists react to the death of a patient, personally, as human beings, in much the same way as do other people". (Litman, 1965, p. 572)

This personal impact is estimated to be greater than the impact in any other domain (Coverdale, Roberts, & Louie, 2007), qualitatively similar to the loss felt by the immediate family (Sudak, 2007), and quantitatively equal to the loss of a parent (Fang *et al*., 2007). That personal reaction depends on a number of variables including the length of time the patient was known, how they were viewed by the therapist, and the depth of commitment they had shown one another. Having a close therapeutic

relationship with a patient along with a high level of involvement in their care is identified as the key factor affecting a professional's response, followed by the support they received from peers, supervisors and management (Gaffney *et al*., 2009).

One third of Scottish consultant psychiatrists reported having been personally affected by the death of a patient by suicide (Alexander, Klein, Gray, Dewar, & Eagles, 2000). Experiences reported included lowered mood, preoccupation, sleeplessness and irritability at home, coupled with feeling less able to deal with routine family problems. These feelings lasted between one week and three months. A survey of Irish consultants (Landers, O'Brien, & Phelan, 2010) did not differ in terms of the personal difficulties experienced, but some 87% of this sample had experienced some disturbance. These psychiatrists had experienced a mean of 5 patient suicides during their careers. In this survey several items were identified which made the consultant more likely to have been affected: where the patient had recently been an in-patient or recently assessed; where they were the parent of young children and where the suicide therefore had a relatively big impact on the patient's family; and where the suicide was not predicted.

Feelings of shame, depression, preoccupation, disbelief, guilt and self-blame have also been reported in studies of psychologists (Knox *et al.*, 2006). These emotional responses may be processed in phases beginning with shock and disbelief, next

acceptance of reality, followed by self-appraisal and finally working through to resolution (Fang *et al*., 2007).

2.4 Professional impact

The most profound impact this stress could have on a professional's work must be the decision to leave that profession, either by retiring early or changing career. Consideration has reportedly been given to this thought in up to 15% of consultant psychiatrists surveyed in one sample (Alexander *et al*., 2000). Litman's sample (1965) said they were reluctant to work with suicidal patients again, and were preoccupied with preventing another suicide, a finding endorsed elsewhere in psychologists (Knox *et al.*, 2006).

The more commonly reported impact has been on professional practice. Changes occurring include a mixture of positive and negative approaches to the management of suicidal patients. Approaches to management are reported to become more cautious (eg through higher level of observation), more structured (eg in diligent record keeping), and more formal (eg through greater use of legislation). The effect on clinical practice can include reduced self confidence in decision making, and has been reported to last longer than the personal distress (Alexander *et al*., 2000; Landers *et al*., 2010).

Coverdale *et al.* (2007) describe how the emotional impact on a psychiatrist can result in a conflict in future decision making with suicidal patients. Chronically suicidal patients may be capable of resisting suicidal impulses. When working with such patients one

must respect their preference for how to manage that risk. On the other hand acutely suicidal patients' preferences need to be balanced against the immediate risk of suicide. To complicate things further, a patient can move quickly from one category to the other. Coverdale *et al.* argue that strong feelings can unhinge clinical judgement, and result in either avoidance of a decision or overzealous protection and management. Three actions can prevent problems arising in this area: firstly that a clinician acknowledge and recognise that their emotional responses can impact on their decision, secondly that they use reasoned justification of decision making, and finally that those decisions are based on evidence where possible. With respect to evidence, clinicians should bear in mind that prediction of suicide is inherently probabilistic and never certain, while hospitalisation of a patient does not guarantee safety.

2.5 Impact on trainees

Litman's therapists said their first experience was the worst (1965), and this insight has been borne out in studies of a more objective nature. In a study of graduates from a Canadian residency programme, 31% of respondents had experienced a suicide during their training, and for more than half of those that experience had occurred during their first year (Ruskin *et al.*, 2004). The impact was measured objectively by the researchers, using validated clinical scales. 22% had symptoms consistent with acute stress, and 20% had symptoms consistent with Post Traumatic Stress Disorder. Compared with those who experienced a patient suicide later in their career, the impact on first year trainees was measurably greater. Overall, 25% reported the impact was "profound" through the rest of their career. Interestingly, the researchers found a

correlation between the most distressed trainees, those who felt most judged by their peers, and those least likely to seek help. Two thirds of distressed trainees kept to themselves, withdrawing at a time when they were most in need of assistance. About one quarter felt unable to ask for help, even though most knew someone who could help them. While most trainees survived the event with resilience, there was a measurable, important minority who needed support.

Another Canadian study surveyed residents during their training, and found that 61% had experienced the death of a patient by suicide during their residency (Pilkington & Etkin, 2003). 32% of these reported having received education and training on the impact a patient's suicide can have on a trainee. The authors felt that any training offered to residents should include practical advice on what is expected of a psychiatrist in this scenario, as most of the respondents said they felt unprepared to manage.

Trainees are felt to be more vulnerable than senior clinicians because of their close involvement with patients on wards and in the emergency department, their relative inexperience, their limited understanding of what constitutes a normal reaction, and often inadequate support or poorly developed mentoring relationships (Yousaf, 2002). At least two of these factors are modifiable through training programmes – the limited understanding and the inadequate support. In her survey (Yousaf, 2002), 53 London based trainees reported impacts in personal and professional domains just like the consultants described above. Initial responses most often included shock, guilt, grief

and anger. More than 50% had a clinically significant score on the 'Impact of Events' scale at two weeks after the event. More than half also found the experience to be a useful and important learning experience which impacted their practice. It is therefore a potentially adaptive event but could possible impact negatively by making the trainee focus excessively on risk aversive practice. Yousaf (2002, p. 55) comments that emotional symptoms may be amenable to simple cognitive strategies or informal supports from their senior colleagues. She proposes this support strategy should incorporate an acute phase focusing on "psychological first aid", and a latent phase after two to six months where "psychological autopsy" is conducted.

Dewar (2000) surveyed 128 Scottish trainees and found almost half had been affected. 28% had received training on what to expect and how to cope with a patient suicide, and ranked it as moderately or extremely useful. 31% reported distressing personal effects, and 39% described an adverse effect on practice. Importantly, 9% considered changing career and a few did change from general adult psychiatry to another sub speciality where the chance of the experience recurring would be less. While team meetings and critical incident reviews were reported mostly as helpful, in a significant number these did not take place (28% and 56% respectively). In terms of informal supports, discussions with their consultants received variable ratings for helpfulness. While 39% found the discussions held were very helpful, another 6% found them to be very unhelpful. Dewar suggests that training programmes should therefore include advice on how, as a consultant, support can be best provided. Studies are cited that show community based psychiatrists can be more stressed than their hospital based

colleagues due to isolated working conditions, and says this supports the value of peer support and discussion in managing stress.

In a large study of UK trainees (Courtenay & Stephens, 2001), 54% had directly experienced the death of a patient by suicide. The emotional impact felt was severe in 24%, moderate in 51% and minimal in just 14%. Support received was universally deemed helpful, apart from where external counsellors had been brought in to debrief the trainee. A negative correlation was shown between impact and both age and years in practice. Adding further weight to the argument that trainees are more vulnerable, a study of psychology trainees (Knox *et al*., 2006) showed therapists in training can experience more severe and longer lasting reactions than their supervisors. Courtenay and Stephens (2001) summarise that support should include strategies to allow and encourage ventilation and normalisation of feelings, and dissipation of ideas of guilt, blame, or isolation.

Because of the special vulnerability of trainees, Puttagunta *et al*. (2014) carried out a meta-analysis to ascertain a reliable figure of those affected. Eight studies were included, the more highly powered and methodologically robust of which showed that between 47% and 69% of psychiatric trainees experience the death of a patient by suicide during their training. The authors summarise the implication for academic leaders:

> Methodologically strong research is needed to inform a priority for developing programs that assist psychiatric residents with managing the death of a patient by suicide. (Puttagunta *et al.,* 2014, p. 540)

Balon *et al.* (2014) describe how the formation of the professional identity of a psychiatrist occurs during their training, and it is during this critical period that new professionals learn "how to weather negative outcomes". The role of supervision is critical to trainee's professionalisation experience, helping to shape behaviours and coping skills. The suicide of a patient can have a profound effect by undermining that emerging professional identity and evolving sense of competence (Prabhakar *et al*., 2014).

2.6 Important roles and considerations

Only 19% of senior psychiatric trainees on the verge of holding leadership positions feel comfortable managing a case following an unexpected death by suicide (Puttagunta *et al*., 2014), particularly the practicalities of contacting families, managing records, informing the staff at large, and organising psychological autopsies. In an Irish context, front line staff in Emergency departments feel similarly ill equipped, and requested more precise information regarding roles and responsibilities of the professional regarding attending funeral and supporting bereaved family (Gaffney *et al.*, 2009). Specific training in responding to the needs of families and others would alleviate this discomfort. Kaye and Soreff (1991) define "postvention" as activities that serve to reduce the after effects of a traumatic event, and divide the areas to be considered into three: the family, the staff, and the doctor.

Psychiatrists often tend to avoid bereaved families in these circumstances. Families want to be contacted by the treating doctor, suggesting trainees need guidance on how to work with families (Fang *et al*., 2007). Several papers provide guidance and advice for psychiatrists on how best to liaise with and support families and staff in these circumstances (Campbell & Fahy, 2002; Kaye & Soreff, 1991), and also advise a particular type of case review for the benefit of the doctor.

Ruskin *et al.* (2004) suggest that focused reviews should be conducted by an external, unconnected senior clinician, thereby promoting learning and avoiding judgement or sanction. Formal enquiries should be deferred until after these reviews have taken place (Coverdale *et al*., 2007). So called psychological autopsies ensure that feelings among staff are shared openly, and can be cleansing rituals that bring about policy reform, learning and better standards of patient care (Kaye & Soreff, 1991). A two step process is recommended (Campbell & Fahy, 2002), first the reviewer gathers all the information pertaining to the case, including documentary evidence and interviewing staff. Next, feedback on the findings is given to the team, when a discussion can be guided by the reviewer on best practice, suggestions for improvement, and any other relevant learning. Conducting a review where the focus is on learning from the case, by identifying the individual factors leading to the death, can impact the professional response positively (Gaffney *et al*., 2009).

The psychiatrist must retain awareness of personal and professional impacts, and acknowledge them if present during the immediate aftermath of the suicide. This can be especially important if the clinician has to continue working and managing patients while attending to the practical issues. Compiling a checklist of these practical issues is advised (Campbell & Fahy, 2002) Attending the funeral is not an admission of responsibility, and can be very helpful in coming to terms with the loss (Alexander *et al*., 2000; Pilkington & Etkin, 2003). By doing so the doctor can provide an example to other staff, display their leadership through their behaviour, honesty and openness (Kaye & Soreff, 1991).

2.7 Helpful support and supervision

Litman concluded that the best way therapists had of coping with the suicide of a patient was by adopting the following attitude:

> to use the experience to enlarge their own psychologic horizons, to become more sensitive as persons and therapists, and to improve their professional judgement and actions. (Litman, 1965, p. 576)

He also suggested that great psychological benefit could be derived from supportive conversations with fellow professionals, and especially by presenting the case to a group of fellow professionals in the hope of learning from it. This impression was borne out in a large study of front line staff in Ireland, including nurses, psychiatrists, emergency medical technicians (EMT) across regional, community and acute hospital services (Gaffney *et al*., 2009). This study focused on supports received by front line staff, and made suggestions for improvements. 32% of their respondents reported they

had not been supported in any way following a suicide (46% EMT, 42% nursing, 15% psychiatrists), while over half the sample felt a need for support, which they defined as simply having time to talk and be listened to. Support from immediate colleagues was more valued than other external supports. The striking feature of this study of a variety of health professionals is the variability in response – much as each client suicide is unique, so too is the individual response in the health professional. This implies that the type and level of support required needs to vary, taking into consideration the needs of that professional.

The role of a supervisor in training a clinical psychologist is more central, structured and possibly important than in other mental health disciplines. This role was examined by Knox *et al.* (2006) having concluded from the literature in psychology that the response of the immediate supervisor to the (trainee's) client's suicide is a critical factor in influencing how the event personally or professionally affects trainee development. The qualitative approach used in this research revealed a richer and deeper understanding than possible from surveys, and important themes emerged through this approach. Trainees felt the delivery of bad news with gentleness and respectfulness was vital - those who were casual or callous prompted negative responses. Supervisors need to be thoughtful in their approach to delivering difficult news, as trainees rely on an immediate and supportive response to prevent further trauma and isolation. Participants stated that their supervisors sharing their own experiences was helpful. So too was provision of a safe environment for trainees to express their feelings, reassurance that they were not at fault, and normalising their reactions.

Some participants also described unhelpful approaches employed by their supervisors worth noting, for example being put “on the spot” to share feeling in team meetings before they were ready to do so. Others described their supervisor as unresponsive to the suicide itself, particularly when describing it as an inevitable event in the career of a therapist. Some supervisors appeared to their trainees to be more concerned with legal and technical ramifications, attending to the formal requirements before the needs of the trainee. They felt this was insensitive and might damage the supervision relationship. The authors of this paper recommended training for supervisors, emphasising a need for formalised training with proactive and reactive components.

Irish doctors preferred informal discussion with colleagues for support, and felt it should be left to the individuals discretion when, where, or if they wished to seek formal support (Landers *et al*., 2010). Scottish doctors (Alexander *et al.*, 2000) never found families and friends unhelpful, meetings with team colleagues and peers were ranked almost universally as helpful, while the deceased patient’s families divided opinion. Two thirds felt it very helpful to attend the funeral, but commented that one needs to be prepared for and learn how to deal with patient’s families. Both sets of doctors believed a focus on learning rather than blaming was important, and meetings should be clinically focused rather than concerned with legal consequences. Kaye and Soreff (1991) suggest that the most helpful type of support in the short term is practical advice, that a senior support figure or mentor should help in compiling a checklist of duties to attend

to, review the case only briefly, and defer any “Where did I go wrong?” type questions. It is also suggested that in this initial contact, the supportive colleague should help with any difficulties in managing other patients (Campbell & Fahy, 2002).

Fang *et al.* (2007) highlight the variability in specific training and supports available to US residents, and recommend that the support person available to trainee should be someone who is known well and trusted. Lack of support is shown to be associated with increased distress, while if responsibility and guilt is shared, trainees fare better. The advice for the supervisor is to check in immediately with their trainee, review the case together soon after, and prepare the trainee for any reviews scheduled to occur, explaining the purpose, procedure and possible outcomes.

While some of the papers discussed above provide concrete examples of helpful support and provide guidance for supervisors, the word support is generally undefined, and the recommendation to seek informal support may merely reflect the lack of a formal alternative (Foley & Kelly, 2007). In the next section the experiences of the few formal programmes which have been evaluated are presented.

2.8 Training programmes

Almost all of the papers discussed in this review concluded that formal training programmes for trainees and their supervisors are called for, and that institutions have a responsibility to help trainees deal with their trauma. An early model for support included an anticipatory phase, where trainees might imagine their response in a secure

environment with their supervisor, followed by a postvention phase in the event of a death, incorporating team and institutional practices, as well as individual work (Michel, 1997). This model did not recommend any specifics on what the postvention with a trainee might comprise, other than an interval session to assess for resolution, but highlighted the need for this to occur individually and distinctly from the team. The supervisor should not take a prescriptive approach to support, rather tailor support individually depending on that individual's adaptive style. Others (Coverdale *et al*., 2007; Fang *et al*., 2007) have observed that an evidence base is needed for interventions, as most research in the area is observational, and argue that programmes should be researched for utility and effectiveness.

Foley and Kelly (2007) piloted a scheme of monthly departmental meetings in a "Journal Club" format where research on the topic was presented and general issues were discussed. They postulated that simply by holding such meetings therapists may be better prepared to cope in the event of a suicide, though were unable to evaluate this scheme's success in doing so.

Prabhakar *et al*. (2014) piloted an interactive curriculum entitled "Collateral Damages" which they were able to evaluate for effect. This programme comprised four elements:

1. A video with brief vignettes and panel discussion
2. A presentation containing information on suicide epidemiology, emotional responses to suicide, and overview of resources available.

3. Patient based case learning exercises

4. Pre and Post questionnaire

160 US trainees completed the 90 minute training across eight clinical sites. Significant improvements were observed in trainees' general knowledge related to suicide, awareness of the potential personal impact, what practical steps to take in the event of a patient suicide, awareness of support systems available and requirements related to documentation. Participants also reported they would be more likely to attend the funeral of a patient and arrange to meet with the training director, having completed the programme.

Overall, 86% of participants felt the programme had improved their understanding of the issues related to patient suicide, while 23% said they had a much greater understanding as a result. The researchers concluded that the curriculum worked well as a part of a broader training programme, and they felt that the design incorporating testimonials from expert clinicians, small group work allowing for personal reflections and narratives, and case based discussions worked well. Significantly, 20% of the participants had already experienced the death of a patient by suicide, and the researchers cite this fact in their argument that any similar programmes should be undertaken as early as possible in training, a suggestion also made elsewhere (Coverdale *et al*., 2007).

Lerner *et al.* (2012) piloted a similar programme in the US, with 42 participants, 12% of whom had already experienced the suicide of a patient. The aim of this programme was to help develop basic understanding of important issues that may arise. It consisted of a biennial half day workshop on medico-legal issues and coping skills, as well as an "as required" module for individual work in the event of a suicide. The workshop comprised large group lectures, small group discussion with faculty who had experienced patient suicide, and a lecture from a guest who had lost a relative to suicide. The "as required" part was intended to run in addition to the normal hospital led enquiries and any other responsibilities of the clinical site, and involved faculty and the chief resident providing further information with the primary purpose of focusing on emotional support, institutional processes and learning. Large and statistically significant increases occurred in both knowledge and self-perception of confidence in addressing emotional aspects. The authors were not able to study the "as required" component as the overall number of participants was so small.

Finally, Figueroa & Dalack (2013) evaluated a model for educating a mixed group of clinicians. They state that the goal for clinicians following the suicide of a patient is to obtain supportive, educational, and professional guidance and understanding from colleagues, and especially for trainees from their supervisors. Their "Retreat Model" involved a half day symposium to be run on alternate years for a mixed group within a mental health department, including psychiatrists, nurses, psychologists and social workers. These clinicians had a range of experience, from the most senior to new trainees. The objective of the retreat was to provide information, with the hope of

reducing the stigma a clinician can feel, which can build up over time, particularly if a clinician experiences several patient suicides.

The retreat began with a presentation on the literature, followed by brief structured case presentations by a panel. The group then broke up into smaller groups for facilitator led discussions, with questions to guide and encourage voluntary contributions from the group. Finally, the large group reconvened for a summary of discussion points from the small groups, a summary of the resources available to the clinicians in the department, and a final discussion.

103 clinicians (20% of whom were trainees) completed a survey of their experiences and expectations for the retreat. 47% of the group had experienced one or more patient suicides, of whom 37% reported the first occurred during their training. One expectation was to obtain guidance on how best to support a trainee under supervision in the event of the suicide of the trainee's patient. Following the retreat, 45 participants completed another survey. Almost all felt they would be able to apply the information obtained to their own professional practice. 87% said they would want to participate in a support group with colleagues. Individuals reported how they felt it was beneficial to hear the reactions of others, especially experienced colleagues. Many noted they felt they were now more sensitive to the needs of their trainees, and were more motivated to provide guidance.

The quality of the evidence to support this retreat model is limited due to the qualitative and narrative data gathered. The authors plan to develop the model and the questionnaires used based on the feedback. They emphasised the importance of the setting of the retreat in the study design, they felt the safe, supportive and structured setting helped in promoting sharing and therefore learning, particularly in those with limited experience.

2.9 Summary and Conclusion

In this review I have presented the common emotional and professional impacts a patient suicide has on clinicians, and highlighted the vulnerability of trainees to these effects. I have illustrated the types of support and supervision shown to be valuable, helping to prevent these consequences. On support, Gaffney *et al.* (2009, p.652) conclude from their study:

> the most useful single measure in terms of professional support, training and preparation in the area of client suicide would be to foster a culture of openness in which suicide is anticipated as a possible outcome even with excellent standards of care.

Learning, rather than blaming, is recommended as a helpful perspective, echoing Litman's view (1965) that support should always be offered. I have described a number of interventions studied aimed at bolstering the supportive practices that already exist in various clinical settings.

The literature presented illustrates that losing a patient to suicide is experientially different to losing a patient to a disease process. A balance must be found between viewing patient suicide as an inevitable part of the natural history of an illness, leading to nihilism among clinicians, versus viewing it as a totally preventable event, which could lead to a culture of blame or failure and shame. Leaders in the mental health professions have a responsibility to strike this balance, and in doing so they can protect their trainees. Trainees in medicine, surgery, nursing, psychology and many other disciplines also experience distress following unexpected deaths and could learn better supervision and coping from psychiatrists, once an evidence base is broadened through further research of specific training programmes.

Chapter 3 - Methodology and Methods

3.1 Introduction

In this chapter I will discuss the development of change management in organisations, particularly the move from viewing change as an isolated event to one of incremental development in dynamic systems. I will discuss the Senior and Swailes (2010) Organisation Development (OD) model in terms of the structure and strengths that make it a good fit for my project. I will then delineate a plan for how my project will proceed using the OD framework.

3.2 Critical Review of Approaches to Organisational Development

A change model is a device which helps onlookers to understand the change process, and undertake change management. Organisational development (OD) is often said to have begun with Lewin's model of change (1951), and newer models of OD, while different, still have their roots in Lewin's model. His model was a linear process, illustrated in Figure 1.

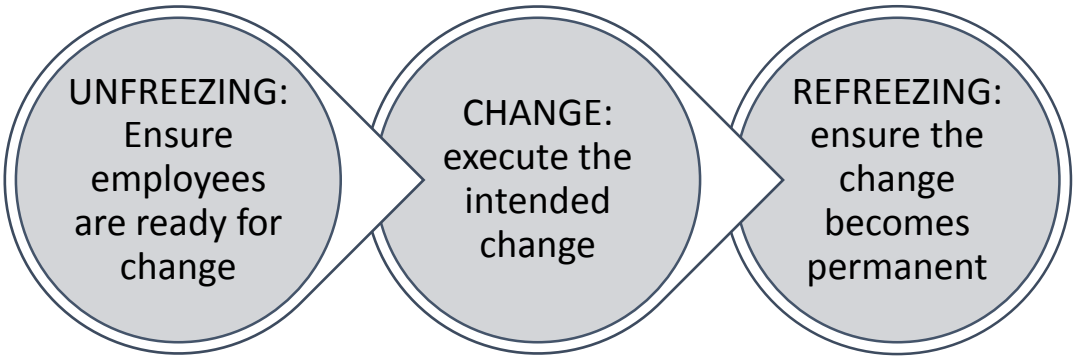

Fig. 1 Lewin's model of change Adapted from Lewin, (1951)

Critics of Lewin's model drew attention to the suggestion that organisations are static entities, that someone could "unfreeze" at their command and "refreeze" when they were satisfied. The reality for any organisation made up of humans, who operate within systems and an environment of complexity, is that change is not an occasional and controllable event. Organisations generally have complex systems within systems, all existing in a dynamic state of flux with the environment.

Bringing about a change within a system is not a simple one off practice, but an action that can bring about reaction in every connected component. OD models, recognising this, have progressed in complexity from Lewin's starting point, primarily in order to take

the environment into account. The move from models of change to *development* reflects the continuous nature of change within organisations and with their environments.

Senior and Swailes (2010) provide several definitions of OD (p 316), and description of what OD models should comprise. They argue that meaningful models should pay attention to detail from all aspects of organisations. They need to consider powers within and politics of organisations, the cultural context, and have a redefined and individualised meaning for each organisation to which they are applied. That meaning encompasses ownership, communication, commitment and participation. Models paradoxically need to accept that chaos will exist to some degree in every model. For example, every person within an organisation addresses that organisation in an individual and unique way informed by their understanding and background. A change to just one person's attitude can change the attitude of every connected person within the organisation, ethos spreading throughout. OD models should reflect that interconnectedness.

> "OD challenges the assumption that a single important cause of change with clear effects can be found, as well as the assumption that any cause and it's effects are necessarily closely related in space and time"
>
> (Senior & Swailes, 2010, pg 319)

OD is less about reacting to the impact of one change, and more about anticipating, diagnosing and managing effects, without having to react to the unexpected. OD models in practice can be time consuming to utilise, are suitable for slow and

incremental development, not for crises, where rapid or transformational changes are required. Another principle of OD to mention is the emphasis on process and culture rather than goals. This has been called a weakness as objective results are difficult to quantify using the complex systems, long time period and often all in the absence of built in analytical tools.

OD should involve and be supported by top management, as well as the actors in the organisation who will be involved directly in any change process. A “change agent” or facilitator exists to try and harmonise the chaos between management and actors, to bring about cohesion and collaboration at all levels. OD processes have two characteristics, a framework of recognisable phases to move from the present to a future state, and a collection of activities within each phase facilitating movement from one phase to the next. Finally, OD models view planned changes as fluid and adaptable as their environment changes, having moved on considerably from Lewin’s fixed and linear model.

3.3 Rationale for OD Model Selected

Selecting an appropriate OD model can be the difference between success and failure before a project even begins, and to help choose wisely three considerations are highlighted:

- It should be understood and feasible to work with

- It should fit the organisation as closely as possible
- It should be sufficiently comprehensive to facilitate the collection of data without omitting important bits of information

(Burke, 1994)

The Senior and Swailes (2010) model fulfils these criteria. In their model the importance of the change agent, in bringing harmony to a chaotic system and orchestrating development, is emphasised by positioning them at the centre of the process (Fig 2).

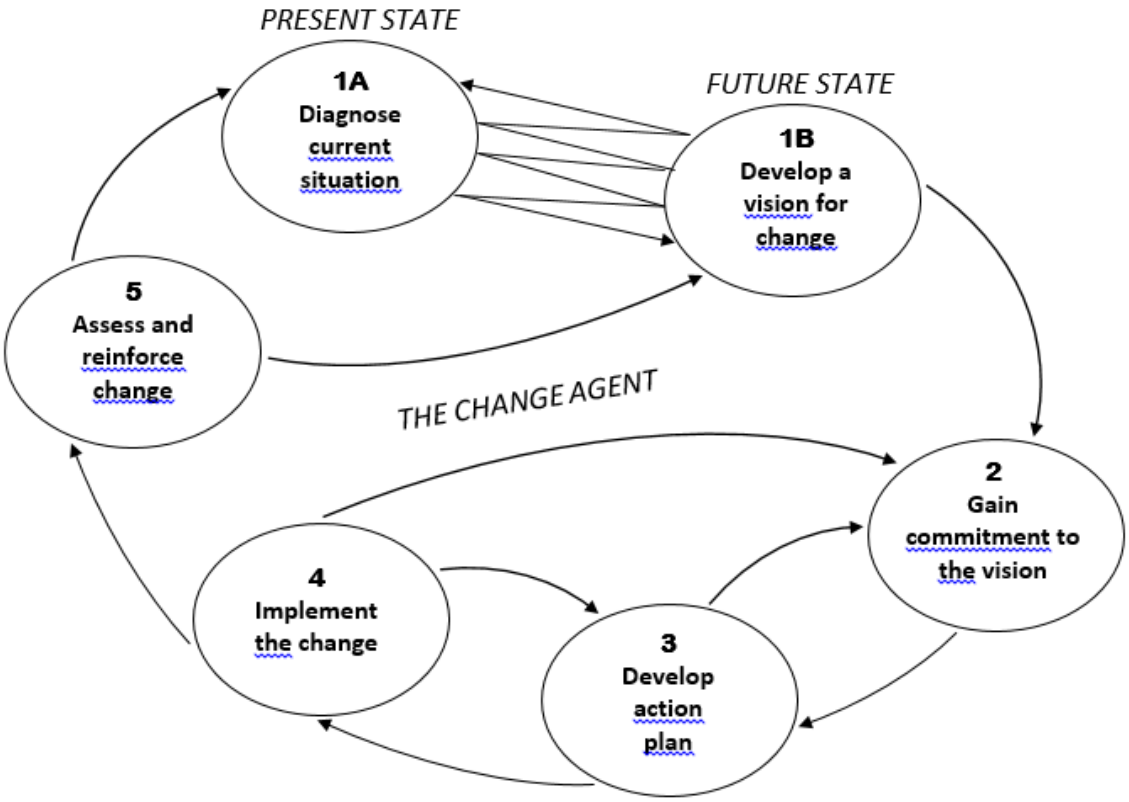

Fig 2. Organisational Development model Adapted from Senior & Swailes (2010, p328)

This model suits my plan as it has sufficient complexity to capture the realities of an organisation like the College of Psychiatrists of Ireland. The model is somewhat chaotic to look at, but by accepting chaos it allows focus on identities and relationships within the organisation that will help coping with change.

The description of the different phases in this model are accompanied by practical suggestions of what to consider doing during each phase in an action research project, many of which can be utilised in my project. Of particular value is the emphasis placed on “Short Term Wins” during the implementation phase, for my programme a vignette can successfully fulfil this role. When publicised, that story could show unambiguous success, clearly related to the programme, and link the implementation with an all embracing vision for the future.

There are several other reasons why this OD model can be successfully used in this project, beginning with the fact that it uses valuable elements of several other models (Kotter, 1996; Paton & McCalman, 2008). The means of bringing about change and leading development in this model are not set in stone, and even when some parts of an organisation may be inflexible this model allows for that resistance, using it as a source of feedback.

This model has been criticised as being unsuitable for public sector bodies, principally because of the many layers of leadership and management in massive public bodies. It has also been criticised for being biased towards the Western world and unsuitable for more masculine, paternalistic cultures, where uncertainty is poorly tolerated. The CPsychI is not a large organisation, and it is one in which uncertainty is encountered routinely, made up as it is of individual psychiatrists who often hold diverse views, where reaching consensus can be challenging.

The role of the change agent at the centre of this model has been criticised for not being clearly articulated aside from an emphasis on leadership. My understanding of the change agent is clear. As I described previously, the change agent exists to harmonise the chaos between management and actors, to bring about cohesion and collaboration at all levels. The leadership style required is not prescribed, as leadership requirements will naturally vary depending on the organisation and environment to which the model is applied.

Finally, the starting point in this model is interconnected with the development of an action plan in phase two. This design is a good fit for my project, where diagnosing the current situation and developing a vision for the future proceed in parallel, allowing change to occur in both without disrupting progress, in true action research style.

3.4 Senior and Swailes Model

Phases 1a and 1b proceed in parallel. They have begun with evaluation of internal and temporal environments through data gathering which will continue throughout the cycle. As diagnosis of the present state is undertaken, vision for the future emerges, through creative thinking and often evidence based practice which is a stimulus for change. At some discrete point in time during this cycle, a clear statement of the vision should be articulated, allowing the organisational development team move to the next phase, gaining commitment.

Unless consultation with senior management and leadership has occurred prior to this phase, there will be little incentive for “buy-in”. With senior stakeholders on board, many way communication to all individuals impacted by the programme can begin. It is not sufficient for a change agent merely to inform, they need to listen for feedback, and attend to it here. This resistance to development is a rich source of data. Being sensitive to fears and worries within an organisation, and ensuring emotional readiness to change, will assist in reaching agreement regarding development of an action plan.

The action plan marks the beginning of the phase managing transition, while commitment building continues. The important issues here are the “who, what and where” of a change. A process called responsibility charting can ensure everyone involved is aware of what is required of them. An action plan can be thought of as a road map of activities (Beckhard & Harris, 1987) with the following characteristics:

- Relevance: clearly linked to change goals and priorities
- Specificity: clearly identified, not broadly generalised
- Integration: closely connected parts
- Chronology: logically sequenced
- Adaptability: contingency plans for unexpected events

Implementation of the change is carried out along with intensive data gathering from as many sources as possible. Short term wins at this stage can link implementation with the vision for the future, thereby cementing commitment and reinforcing the future of the change. Assessment and reinforcement continue from here. Assessment can be difficult, as mentioned earlier, without inbuilt systems and plans for evaluation, and when the outcomes of change are not easily and objectively quantifiable. What should always be possible is feedback from individuals indicating how the development is functioning, thereby reinforcing it while placing positive pressure on all other players to accept the new normal.

In the following section I will describe how these phases apply to my project, and present a “rich picture” (Senior & Swailes, 2010, p. 330) of the programme’s planned progression. New data will reshape the vision once the programme begins in earnest.

3.4.1 Diagnose Current Situation

The present state regarding supporting a trainee after the suicide of a patient has been detailed in the previous two chapters. To summarise, the usual approach is on an *ad hoc* basis, dependant on numerous factors including the individual personalities and coping styles of the trainee and their supervisor. There is evidence that some trainees are unhappy with the support they receive, and evidence that trainees and their supervisors feel ill prepared to act decisively in offering or requesting support. There is evidence that support is helpful in preventing personal and professional difficulties from arising, however, the form of that support is poorly defined. Experts and review groups have described the provision of support, as well as research and design of formal support models, as an obligation for training bodies in mental health. The CPsychI oversee specialist psychiatric postgraduate training in Ireland. At present, they recommended no particular strategy for offering routine and consistent support to trainees who lose a patient to suicide. The curriculum for training specifies that trainees meet individually with supervisors for an hour on a weekly basis, this protected time offers an opportunity for providing support, as well as researching models of support.

The extent of the problem for Irish trainees can only be extrapolated from surveys of trainees in similar jurisdictions. In an effort to quantify the exact scale of the problem in Ireland, I approached the training body with a proposal to survey current trainees. Unfortunately, there is a college policy that precludes the use of the trainee database for carrying out surveys, and there is no current crisis that would override that policy. What

does exist is some momentum following a recent systematic review and meta analysis in a prominent psychiatric journal (Prabhakar *et al*., 2014), and an academic zeitgeist of recognition of the need to proactively manage trainees' responses to patient suicide. In response to my proposal to design a supervision guide, the College indicated that the role of supervisors with a trainee following a patient suicide is one that they would be interested in exploring. The response included a commitment to meet to explore how the College could support a research project once an initial plan was formulated.

The College's Postgraduate Training Committee are in a position of power in relation to the success of otherwise of this project. Building on their initial interest and converting it into strong support by phase two will be a determining factor in the successful design and implementation of a programme. As such, they are the key stakeholders, represented along with the other groups with influence in my stakeholder analysis in Fig 3.

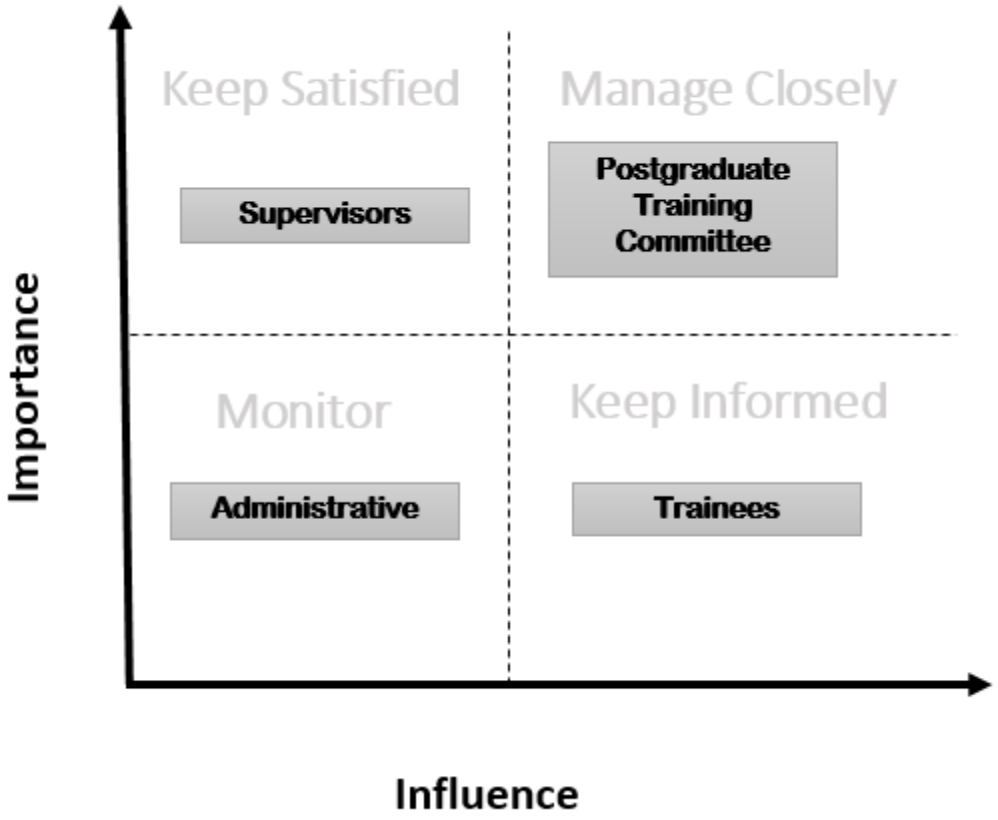

Fig 3. Stakeholder Analysis

The Postgraduate Training Committee need to be managed closely, through effective communication seeking their views. I plan for a representative from within the committee being co-opted to a steering group for the project. Delegates from each of the three other stakeholder groups, along with myself as change agent, will form the remainder of the steering group. Supervisors and trainees who are interested in involvement in the project will become opinion leaders with influence in their peer groups. Steering groups are used regularly in the College for any new initiative, or in the formulation of a position paper, and can fulfil several important functions in this project.

Finally, the organisations goals, as mentioned in Chapter one, complete the picture of the present state and provide a link to a vision of the future.

3.4.2 Develop a Vision for Change

Deciding the precise aim of the project plan sharpens the focus and helps avoid being derailed or side-tracked by issues as they arise. To do this I formulated a vision statement:

> To strengthen the role of supervisors in the aftermath of a patient suicide, by providing the tools to help them deliver effective individualised support to their trainees.

What this will actually achieve can be summed up in a mission statement:

> To prevent the negative consequences of the experience of a patient suicide for psychiatric trainees.

I next determined how quickly I want to introduce and implement an intervention delivering on the above statements. Kotter and Schlesinger (1979) highlight three considerations to assist determining the optimal speed of change in a strategy. Slow pace is recommended if the change agent:

1. Anticipates resistance
2. Has less power than resisters
3. Needs information from others to design and implement change.

A further consideration in determining speed is the stakes involved, whether there is a crisis or urgency requiring a rapid change. For my project, the problem to be overcome

is not new or a crisis requiring immediate intervention. It is clear that the case for introducing this project will not be outdated in the short or medium term. My position in the organisation is one of little power, and clear dependency on the organisation to support and assist the project. A disjointed and incremental plan can be a mistake when not part of an overall strategy (Kotter & Schlesinger, 1979)., however a slow rate of incremental change over three years suits this planned project. The next consideration in enhancing the vision with strategy is to consider what resistance may be encountered along the way.

3.4.3 Gain Commitment to the Vision

New initiatives can be feared because of a threat to the status quo and to vested interests. Predicting, pre-empting and preparing for resistance in an accurate and timely fashion can prevent problems arising, and is the best way of overcoming the barriers those problems may present. If the sources of resistance are managed in this project we will avoid passivity or aggressive undermining by the participants, and foster an attitude that will see the programme sincerely embraced.

The most likely source of resistance to this project is from the consultant supervisors who will be asked to be active participants. In general, doctors do not particularly fear or have a low tolerance for change. Practicing evidence based medicine requires regular adaptations to practice in the best interest of patients. However, foisting or demanding a change in supervision practice without a strong evidence base could meet with

resistance. Individual supervisors may fear this project if it is implemented tactlessly. They may misunderstand the aim, and think that the project is somehow implying their previous attitudes and behaviours were wrong. They may feel criticised and resist in order to save face. Many supervisors value the autonomy they and their trainee are granted in supervision sessions, and may think that being directed what to discuss is an unfair violation of this autonomy. Finally, it can be difficult to reach a consensus among a large number of supervisors, not all of whom may believe that the project makes sense or is needed.

These sources of resistance can be overcome through judicious use of methods described by Kotter and Schlesinger (1979). Education and communication before and throughout the project will help to overcome misunderstandings about any implied criticism, or lack of belief. This can be achieved by signposting the project well in advance in the college newsletter, and in posters and presentations at bi-annual academic meetings. Participation and support from the supervisors in the design and implementation will help overcome any perceived lack of control or perspective in the programme. Open lines of communication and requests for feedback from supervisors, individual meetings and focus groups, and enlisting of supervisors in the steering group are time consuming activities, but these strategies will be worthwhile when they help ensure commitment and not merely compliance. Finally, providing training and designating facilitators to listen and support the supervisors with any difficulties will help allay any fears or anxieties that may lie at the heart of resistance.

Trainees may fear the introduction of a new programme in an already busy and demanding curriculum. They too may misunderstand the purpose of the project, and resist through a feeling of not being heard. These sources of resistance can be managed similarly, through education, communication and involvement in a similar fashion as the supervisors. Their opinions and experience can be garnered through questionnaires as they participate, as well as focus groups and enlisting trainees in the steering group. The benefits should be clearer to the trainee intuitively, they can also be encouraged that by participating in this they programme they obtain an additional objective measurement of their training to show to potential employers in the future. Finally, as the trainee is in a position of relative weakness in the organisation, there could be explicit direction to comply in order to proceed in their training. This strategy would need to be used cautiously, trainees left feeling manipulated and threatened could jeopardise the success through incomplete participation.

Lastly, the organisation itself, the CPsychI, will have a number of issues to overcome to ensure commitment. Taking a pragmatic view, financial resources and manpower are limitations in the organisation. Less obvious are relationship problems between supervisors and the organisation. In this case the costs will be minimal as supervisors and steering groups, as well as myself acting as the change agent, all provide expertise and attend to their duties on a voluntary basis, while difficulties in relationship can be improved by this project. Longer term savings may be made through reduced rates of absenteeism. The College can show they are mindful of the difficulties some supervisors face in supporting their trainee, and will be seen taking action to address

those difficulties. A strong supporter of the project within the organisation will need to be recruited. Finally, inertia can be a source of resistance in small projects within organisations. The College's agreement that this project is valuable and is worth exploring further is a positive sign. With any healthcare change, putting patient's interests at the centre can help overcome inertia. This programme will benefit both patients and staff. This fits with the goals of the organisation detailed in chapter one. Finally, the question of risk reduction can be explored, as any organisation will get behind an initiative that reduces risks to their success.

3.4.4 Develop an Action Plan

The action plan for this project will be developed through consultation and collaboration with all the interested parties within a steering group. It is important to restate that the action plan outlined is a preliminary plan, subject to change and revision when data gathered in the previous phases are taken into consideration.

I plan to pass the programme through three one year cycles of development, each building on the data gathered during the previous cycle. During the first year, a steering group will be formed which will reach consensus on the components to make up the guide for a one hour supervision session. This will include a brief discussion on suicide demographics and risk assessment for clinicians, but will focus on the evidence

highlighted in chapter two. The impact on a clinician's personal and professional life, and considerations to make in the aftermath of a patient suicide, will be presented. The guide will include expert testimonial in the shape of a vignette, which will prompt exploration by trainee and supervisor of their expectations and fears. It will include a proposed action plan for support for the trainee with their supervisor, with timelines and suggestions for when, where, and in what format, discussion will take place relating to a case in the event of a patient suicide. The session should conclude with information on other formal lines of support available locally (Appendix D).

My proposed action plan would see the session taking place over two to three weeks in one clinical site, between 6 to 10 trainees and their supervisors. Evaluation will be discussed further in chapter four. Focus groups with supervisors and trainees will be held to provide information on any strengths of the programme, difficulties experienced in the session, and suggestions for improvement. Of particular interest will be the supervisor's perspective on whether or not they would benefit from some separate training before the session.

Cycle two, in year two, will build on cycle one. The scale of implementation during this cycle will be informed by the outcome of evaluation of cycle one, but could see the programme being introduced in one region comprising several clinical sites and 25 or more trainee/supervisor pairs, taking four to six weeks to complete. Evaluation of the session will proceed as for cycle one, with questionnaires, focus groups, and additional

individual interviews for feedback from supervisors. Of particular interest here and during cycle three will be the experience of any trainee/supervisor pairs who experience the loss of a patient through suicide having completed the session. Individuals will be encouraged to contact the steering group to arrange interviews aimed at providing feedback on the impact of completing the session, whether it give them confidence they were providing the best support for their trainee.

Finally, cycle three would see a national implementation of the programme with oversight from the steering group, who will now be complemented by additional administrative support. An external expert may be contacted for process consultation early in cycle three. Any unforeseen issues arising from the data gathered during cycle two would be dealt with, before the programme is implemented for all trainee/supervisor pairs nationwide over the course of two to three months.

3.4.5 Implement the Change

The programme will be evaluated through each of the cycles, using the plan outlined in Chapter four and in the action plan phase above. Important components to mention here include short term wins garnered through student satisfaction measures and case vignettes.

3.4.6 Assess and Reinforce the Change

Again, assessment plans will be discussed in more detail in Chapter four. Reinforcing the adoption of the supervision session as a routine practice will occur through dissemination of the evaluation results, generating a rich picture of the new normal.

3.5 Summary and Conclusion

In this chapter I have summarised the evolution of Organisational Development models, and discussed the Senior and Swailes OD model in detail. I have described how my project plan fits into the initial phases of the model, considered the resistance that may arise from various sources, and explained how these issues can be used as a source of feedback which can be used constructively in the planning, to raise awareness, build engagement, and help shape the change as it proceeds. Finally, I have outlined how I envisage the programme proceeding through the later phases of the model.

Chapter 4 – Evaluation

4.1 Introduction

This chapter will provide an overview of evaluation in relation to my programme plan, paying attention to the design, usefulness and limitations of various models of evaluation. Education is the science of learning and changes occurring within learners, one aspect of which is the aspiration to rigorously and methodologically examine and discover the right way to educate (research in education), another is to continuously examine whether those ways are working as anticipated (evaluation of education). The evaluation cycle is presented visually in Fig 4. Evaluation has been defined as:

> "A method of measuring the extent to which an intervention achieves it's stated objectives".
> (Lazenbatt, 2002, pg 71)

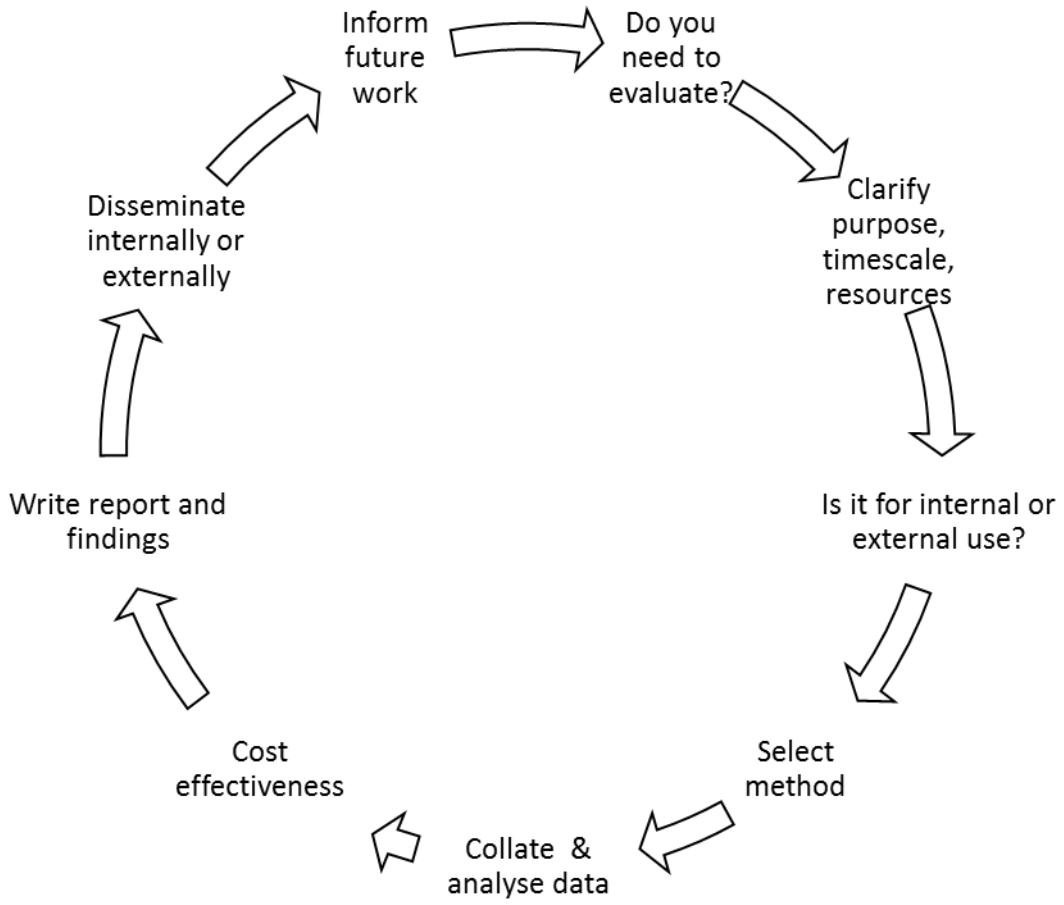

Fig 4. The Evaluation Cycle Adapted from Lazenbatt, (2002)

In this chapter I describe challenges for leaders in academic settings when it comes to evaluating programmes and curricula like the one I am planning. I will explain the rationale behind the models chosen to evaluate my project, by asking key questions, and by citing examples of these models applied in higher education. Finally, I will describe the detail of the proposed evaluation of my project, in relation to the aims, methods, expected results and dissemination plan.

4.2 Overview of Evaluation in Education

In education, evaluation is often confused with assessment (Goldie, 2006). Assessment measures a student's performance, but evaluation seeks to understand why the result of those assessments are not 100%. In this way assessment can be considered one component of a thorough evaluation. Explanation of the difference can be achieved by evaluation of teaching methods, effectiveness of a programme, engagement of the student body, among other things, thereby allowing adjustments to be made so the student's results more closely approximate an ideal. Evaluation can be described as a value judgement of a programme's worth (Cook, 2010), the purpose of which is:

> "to deepen the knowledge and understanding of learning and education by studying phenomena, relations and how and why what works for whom"
> (Ringsted, Hodges, & Scherpbier, 2011, pg 696)

Evaluation begins with methodological and systematic collection of data and information from various sources, information related to design and implementation of programmes, as well as the outcomes where possible (Frye & Hemmer, 2012). The information gathered is evaluated in order to both monitor activity and improve quality and effectiveness of the programme. It differs from research in that variation in the information gathered is expected and valuable, and does not imply weakness or limitation, it is used constructively to examine application of the research in real life.

4.2.1 Evaluation and the Challenges for Academic Leaders

The stimulus to the development and evolution of evaluation theories and practice through the twentieth century was stakeholder influence. During the 1960's increasing

investment in educational programmes and institutions led to increased accountability for academic leaders (Goldie, 2006). Their challenge was to show their institutions provided value for money to financial investors. Evaluation models allowing comparison between institutions were developed by academics, in order to objectively prove their value (Goldie, 2006), along with outcome models, which enabled institutions to show change occurring in their students.

Over time other stakeholders including teaching staff and the student body became increasingly influential (McNamara, Joyce, & O'Hara, 2010). In healthcare, patient representative groups demanded accountability from those educating health professionals. Curriculum development staff felt dissatisfied as they found little virtue in the existing models for determining the effectiveness of their teaching materials and methods. Academic leaders, reflecting on their experiences using outcome and comparison based evaluation models, recognised the limitations of these models in satisfying their many stakeholders. This brought about a period of change and diversification in evaluation theory and practice.

Cronbach argued that evaluation should focus on decisions made during curriculum development (Cronbach, 1963). He felt that comparing two programmes was less important than evaluating how closely a programme's stated objectives were met by it's instructional methods. Academic leaders responded to stakeholder dissatisfaction by

developing qualitative evaluation models which looked at the quality of programme implementation, and the causal processes mediating programme impact (Goldie, 2006).

McNamara *et al.* (2010) argue that the latest challenge for academic leaders is to complement evaluation for external purposes with self-evaluation from within their organisations. By empowering teachers to examine their own methods and practices, the focus is shifted back from an external locus of control. Stake (Abma & Stake, 2001) argues that just as teachers should aim to complement didactic teaching with discovery learning, academic leaders should promote discovery evaluation from within. This can benefit both students and teachers, as the quality of student learning is increasing being understood to have a direct relationship to the quality of educator's professional learning (McNamara *et al.*, 2010).

Finally, evaluation is often thought of, incorrectly, as being an agent of change, and that an evaluation is only successful if a change occurs. A challenge for academic leaders is to see the fault in this assumption, and use evaluation to decide what parts of an educational programme or teaching method are worth cherishing. Arresting deterioration of an educational programme to maintain the status quo can also be thought of as change (Abma & Stake, 2001), but it takes deep understanding of evaluation by those in leadership positions to recognise this.

The leadership challenges facing this programme's evaluation include satisfying the stakeholders discussed in chapter three, designing an evaluation that can be sensitive to those demanding objective outcomes, as well as those more interested in qualitative data. Those implementing the programme will need to be empowered to evaluate from within, and the complete evaluation will need to provide guidance on whether the programme merits a change from the status quo.

4.3 Models of Evaluation in Education

System theory in evaluation assumes that there are complex and dynamic relationships between components leading to an outcome (Frye & Hemmer, 2012). It acknowledges that systems are dynamic and complex, and linear relationships between component parts cannot be assumed. Any outcome can be reached by a variety of different routes, depending on the states of component parts and their relationship with each other and the environment. In order to wholly understand an outcome one must at least consider the chaos within a dynamic system. Most modern educational programmes contain complex components and non-linear relationships. Student's and teacher's personalities, external influences, and the cultural zeitgeist are among the dynamic factors considered in complexity theory, which can be considered as system theory applied to evaluation of educational programmes (Frye & Hemmer, 2012).

Evaluation models can also be categorised by their focus and utility. Choosing the correct model for an individual programme can be aided by understanding the goal of

undertaking an evaluation (Cormac, 2000). For example, if an evaluation was being designed to show efficiency and economy of intervention, a “goal-oriented” model would be suitable, whereas an evaluation designed to obtain perspectives of individuals within a programme would require a very different “participant-oriented” approach. Models exist in order to evaluate process, outcome, impact, and a variety of other areas of interest. I will next provide brief descriptions of commonly used evaluation models that I considered utilising for my proposed evaluation, before providing the rationalisation behind my choice.

4.3.1 Kirkpatrick’s four level evaluation model

Kirkpatrick’s models (1959, 1976, 1994) widespread use and popularity amongst evaluators has been attributed to the systematic, straightforward, and understandable design, as well as the fact that it was one of the first models proposed for use in training and education (Bates, 2004). In this goal-oriented model, Kirkpatrick delineates four levels of outcomes:

1. Reaction – based on satisfaction of, or utility to, trainees
2. Learning – measuring quantifiable indicators of learning
3. Behaviour – a measure of the extent to which training is applied, or by enhanced job performance
4. Results – measure of impact on broader organisational goals or objectives

Anyone who has attended training courses will be familiar with feedback forms regularly provided, where participants are invited to score their satisfaction with the course on a Likert scale, and rate the trainer. These simple measurements are often referred to as “happy sheets”, as more often than not the feedback is positive. It could also be termed “happy” for an evaluator, as this level of evaluation is easily gathered and quantified. Kirkpatrick’s model stresses the greater importance of the information as the level increases. Organisations are said to like the model as there is a focus on outputs and objectives at the higher levels, which they can streamline with their own objectives and thus justify the expense of a training program. Evaluation of each level becomes progressively more difficult to achieve effectively (McNamara *et al*., 2010).

The simplicity of the model is both a strength and a limitation, as it does not take into account dynamic, individual and chaotic relationships and environments that exist in complex systems. The model assumes causal linkage, ie that level one change must occur before higher levels can, and that the more level one change the greater potential for level two change, and so on. The incremental importance or value based on the higher levels of evaluation has been questioned, and the theoretical basis for the design not been borne out in research (Bates, 2004). The design limits the value of participant feedback, as organisations become overly focused on return by seeking change at the highest levels (Bates, 2004). This devaluation of level one measurements obscures one of the principal reasons for evaluation – improving the training for trainees to make it more favourable as well as effective. For these reasons I feel using the Kirkpatrick model alone in the evaluation of my proposed programme would fail to adequately

capture student satisfaction, and would neither be suitable for evaluating the supervisor's experiences

4.3.2 C.I.P.P.

The CIPP model (Context, Input, Process, Product) is a management-oriented evaluation, which does not make the assumption of linearity that so constrained earlier evaluation models (Frye & Hemmer, 2012). Stufflebeam designed the model to address the limitations of traditional evaluation models, with the intention of focusing on improvements rather than evaluation per se (Stufflebeam, 1971).

Context studies are initially used to evaluate organisational structures and strengthen programme proposals. Next, input evaluation studies are useful for resource allocation planning, and can assess alternative approaches while remaining responsive to unfolding program needs or contexts (Frye & Hemmer, 2012), or new developments in training. Programme planners and evaluators can rationalise why a course of action was chosen, or justify changing tack. A process evaluation study then assesses a given programme's implementation, and can be repeated serially to provide formative information for revising the programme. This allows change to occur while retaining the evaluation model. Here, consideration is given to complex environmental interplay with the aim all the while of improving. Finally the product evaluation study is conducted, this wide ranging study identifies then examines all types of outcomes, and the degree to which targeted outcomes were met (Frye & Hemmer, 2012).

The CIPP model's strengths are in its dual purpose in planning and evaluating programmes, at beginning and end points as well as concurrently. Attention to the environment and context is supported. It gives educators scope to consider the processes and choose a course of action based on a rationale, while also helping understand why the outcomes are what they are. It can provide information for multiple stakeholders, funders, students, governing bodies as well as the educators themselves (Zhang *et al*., 2011). While these strengths would suit the aim of my evaluation, I feel the following model is a better fit for capturing complexity in my proposed programme.

4.3.3 Stake's responsive evaluation framework

Evaluation can be considered a comparison of an observed value to a standard, and the evaluator's task is to make a statement of their observation, with reference to the standard expected by stakeholders (Stake, 1975). The difficulty with this simplistic view is that values and standards are never simple numeric values, rather a complex constellation of expectations and criteria varying widely between different stakeholders. This constellation of criteria and expectations encapsulates what I expect to see from stakeholders in my programme. Stake saw a problem with outcome-oriented "preordinate" evaluation, he felt it was a mistake to presume that only measurable outcomes could testify to the worth of a programme. His response to this problem was responsive evaluation.

Responsive evaluation has been described as a doctrine which extends and disciplines common sense (Abma & Stake, 2001). Others categorise it as a participant-oriented approach, in which involvement of participants is central in determining the values, criteria, needs and data for evaluation, where the participants are stakeholders (Goldie, 2006). Stake himself described an evaluation as responsive if it:

1. Is oriented more to activities of a programme than the intents of those activities
2. It responds to its audience's requirement for information about the activities
3. It refers to the value-perspectives of the participants in those activities when evaluating the success and failure of the programme. (Stake, 1972)

Responsive evaluation does not dismiss the worth of looking at antecedents and outcomes, but promotes a broadening of the array of data collected, particularly data on process. Stake said:

> "One should consider carefully what data were needed, and perhaps branch out more broadly than before… the idea of legitimizing opportunities to get relevant data of different kinds…stretch people's minds as to what should be considered legitimate data to collect"
> (Abma & Stake, 2001, pg 8)

While this approach sacrifices some precision in measurement and generalisation of results, it increases usefulness to those persons who are within and around a programme. Stake felt it was a mistake to press for consensus in an evaluation, he was more concerned with "value pluralism", about issues relevant to the on the ground

experience, to the particular, the local, the problems with trying to fit a standardised approach to a nuanced complex local milieu. By examining these issues the ultimate evaluation and decision making is left to the audience (Abma & Stake, 2001). This is reflected in the structure of a responsive evaluation report, which reads more naturally than other formal evaluation reports. This attitude to the local and interest in differing evaluations is precisely what I consider to be relevant for my programme, particularly when it comes to evolving and improving the content and design.

The functional model is represented by a twelve step wheel, represented in Figure 5. Steps can be reduced or altered depending on the requirements of individual evaluations, and there is no defined process through which the steps proceed, rather each step begins at the earliest stage of the evaluation possible, and all are considered throughout.

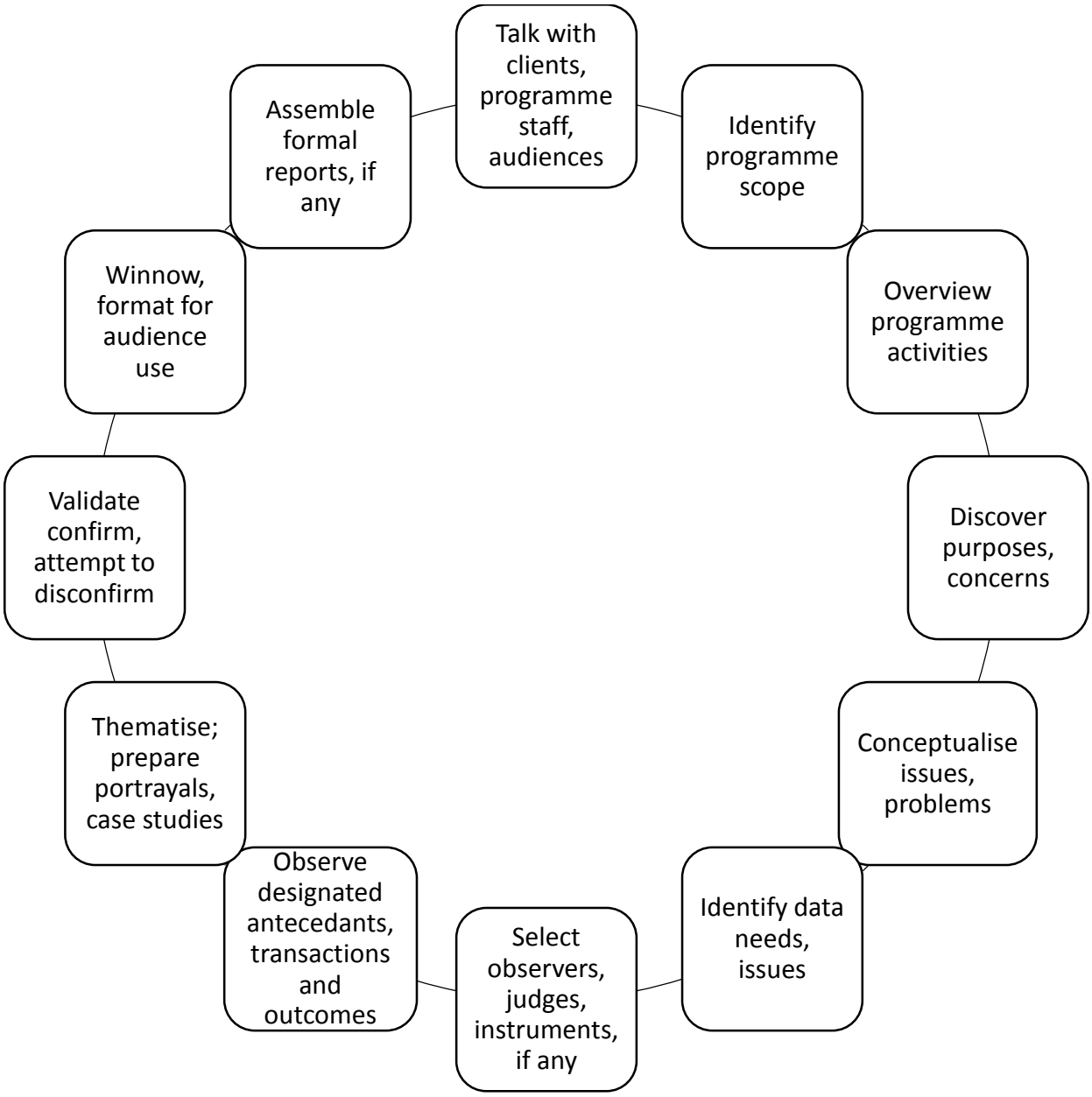

Fig 5. Prominent events in a responsive evaluation. Adapted from Stake, (1975)

Case studies are advocated in responsive evaluation, as a well described case report is concrete and contextual, and open to different interpretations and deep understanding. In this type of reporting, themes and hypotheses are important, but remain subordinate to understanding of the case (Abma & Stake, 2001). “Vicarious experience”, or

anecdote, is also encouraged. Stake said that resistance to change is often directly related to personal experience, and that evolutionary change through self-correcting competence of local practitioners could be supported by including vicarious experience (Abma & Stake, 2001). Finally, the best types of responsive evaluations should include a multiplicity of observers.

4.3.4 Rationale for selection of evaluation model

Choosing the right evaluation model for a project is assisted by taking a systematic approach that begins by asking two key questions:

- From which stakeholder perspectives are you going to evaluate?
- Which stakeholders are you going to involve in the evaluation process and how?

My programme evaluation aims to encompass all stakeholders perspectives, with particular attention paid to the supervisors using the guide. Ovretveit (2002) delineates further questions to ask at the beginning, and advocates taking a checklist approach summarised in Table 1. Choosing the best fit must also take practical factors such as time, skill set, and resources into consideration.

User?	Who is the evaluation for & which user perspective should I take?
Intervention?	What is the service, action, change quality improvement to be evaluated?
Target?	Who or what does the intervention aim to change/improve?
Value criteria?	How will users judge the value of the intervention in the first place?
What needs to be known?	What do users need to know to change/improve what they do now or to make better informed decisions?
Outcomes of interest?	Which data needs to be collected to find out if the targets have been changed/improved or to discover other changes/improvements?
Confounders?	What else could explain the outcomes apart from the intervention?

Table 1. Selecting evaluation models. Adapted from Ovretveit, (2002)

The aim and objectives of my evaluation provide the answers to these questions and are delineated below.

Intervention studies that examine trainees preparedness for patient suicide consider mostly preordinate objectives, using pre and post test questionnaires (Figueroa & Dalack, 2013; Lerner, Brooks, McNiel, Cramer, & Haller, 2012; Prabhakar *et al*., 2014) to evaluate student learning and change. The Kirkpatrick model will be utilised in my evaluation, as a secondary or supporting measure, examining the trainee's experience of the supervision session, evaluating their satisfaction and whether knowledge transfer has occurred. Evaluating for change in levels higher up on Kirkpatrick's model would be unrealistic.

The CIPP model's emphasis on organisational efficiency and production, it's assumption of orderliness and predictability in decision making, and it's narrow focus on the concerns of few (Goldie, 2006) would fail to capture the complexity of individuals and local perspectives. Stake's responsive evaluation framework is a closer fit for what I am seeking to capture, namely the presence of multiple realities, garnered through first hand observations taking place on site, and using discovery and inductive reasoning in the evaluation of success or failure.

The responsive evaluation framework has been used successfully in examination of change and innovations about which little was known (Curran, Cristopher, Lemire, Collins, & Barrett, 2003; Deepwell, 2002), as is the case with my programme. Concern with context and pluralistic emphasis on understanding allows the evaluation plan to evolve through discovery (Goldie, 2006). While it can be argued that subjectivity inherent in naturalistic enquiry is a limitation, the use of this model gives criteria for judging the rigour of that enquiry. There are other limitations and problems with this framework, principally it's high labour intensity and cost, along with the potential to fail to reach closure. I believe these limitations are offset in the context of my project by the goodness of fit. Once more is known about guiding a supervisor in supporting a trainee as a result of this project, hypotheses can then be generated for more outcome oriented research and enquiry.

4.4 Plan for Evaluation of Project

Evaluation of my programme will make use of Kirkpatrick's four level evaluation model, and Stake's responsive evaluation framework, modified for this project. This means a multifaceted evaluation conducted through different phases of the project.

4.4.1 Aims

The aims of this evaluation are:

- To understand and portray the complexity in the programme through the use of inductive reasoning and discovery.
- To make observations of the programme from multiple viewpoints.
- To evaluate for knowledge transfer and student satisfaction.
- To provide usable data that will prompt modification and further evaluation.
- To generate hypotheses for further research.

4.4.2 Methods & Measures

The evaluation will be conducted from the outset, and will continue through three cycles of use of the guided supervision session. The principal researcher will conduct the majority of the on-site evaluations, with support of administrators in the CPsychI. The initial two cycles of evaluation will generate reports that will be used to inform modifications to the guide for the next cycle. All three cycles of evaluation will be used in a final report.

In order to evaluate for student satisfaction and knowledge transfer, pre and post questionnaires will be given to participating trainees to complete. The content will be formulated specifically for this programme, as there are no widely used validated questionnaires in use suitable for this purpose. These will be modified between cycles, based on student feedback and observed utility, to best capture satisfaction and knowledge transfer. This will correspond to levels one and two on Kirkpatrick's four level evaluation. Following the third cycle, the possibility exists for a further questionnaire to be completed by trainees after an interval of three to six months, in order to assess for level three change.

Responsive evaluation will encompass the elements outlines in Stake's twelve steps, and presented in Figure 5 above. The complexity and breadth of data will increase through the three cycles (Appendix C). During cycle one, agreement on the final content of the guide will be reached by the steering group. Evaluation begins here, with examination of concerns and issues raised. During the pilot programme and upon its completion at the end of cycle one, focus groups will be conducted with supervisors and trainees separately, and possibly together. Individual semi structured interviews will be conducted, again with both supervisors and trainees. Participant observations as well as confidential and anonymous feedback will be encouraged in these forums.

This process will be undertaken again during and after both cycles two and three. Additional evaluators will be needed, particularly following the national implementation in cycle three.

4.3.3 Expected Results

Pre and post test questionnaires completed by trainees should demonstrate satisfaction and knowledge transfer. The significance of change, and level of satisfaction, should increase through each cycle. Interval change is likely to be more difficult to demonstrate, particularly if questionnaire return rate is low.

Evaluation of the initial meetings and pilot phase of the programme is likely to generate valuable information, leading to significant changes in the guide for cycle two. The information provided through evaluation of cycle two will assist in making additional changes, and will be of considerable value in determining which components of the guide are most favoured and most utilised by practitioners.

Finally, evaluation of the guide in practice during cycle three will generate very useful information on the success or otherwise of this approach to supporting trainees through the aftermath of patient suicide. Of particular interest will be the vicarious experience, gathered primarily via focus groups and semi structured interviews, and used in construction of detailed case reports. The evaluation is likely to reflect a variety of experiences of using the guide, both positive and negative. These will likely encompass user perspectives on the difficulties experienced, reasons for resistance to further use,

and importantly, perspectives on favourable features and reasons for continued use by supervisors.

4.3.4 Dissemination Plan

Information garnered from the evaluation cycles will be disseminated at the conclusion of each cycle. Following the pilot programme during cycle one, the evaluation will be written and its content agreed on by the steering group before being circulated to all the stakeholders, including consultant supervisors and students involved in the pilot, and the CPsychI. A poster of the initiative, including background information and qualitative evaluation, will be displayed and presented at a national meeting.

During cycle two, a paper will be submitted to an education journal outlining the study protocol and evaluation plan. Upon completion of cycle two, a further paper with background and results will be submitted to the national journal of psychological medicine.

Following cycle three, separate papers will be submitted to international healthcare journals. One will outlining the impact of the programme on trainees in relation to their satisfaction and the change in knowledge. A further paper will describe the use of the guide from a supervisor's perspective, describing its value and limitations, and generating hypotheses for further research. Presentations of the programme and workshops on its use will be conducted at international meetings.

4.5 Summary & Conclusion

This chapter has outlined the value of conducting thorough evaluations of novel educational programmes, by looking at the emergence and evolution of evaluation models which meet stakeholder demands. I have outlined some of the challenges faced by academic leaders in performing evaluations which serve several purposes, and provided brief descriptions of three evaluation models. I have considered the attributes of these models and provided rationale for my proposed evaluation based on those attributes. Finally I have described the evaluation as it will proceed through the implementation of the programme's three cycles and beyond.

Chapter 5 - Discussion and Conclusions

5.1 Introduction

In this chapter I will discuss the potential impacts of this project on the three key stakeholder groups, and outline my impressions of the strengths and limitations of my plan. I will make recommendations that would facilitate the success of the plan, and finish by highlighting my learning about organisational development and planning for change.

5.2 Project Impact

The potential project impacts on stakeholders, current practice, and research in the area are discussed below.

5.2.1 Stakeholders

Supervision is defined as

> The provision of guidance and feedback on matters of personal, professional and educational development in the context of a trainee's experience of providing safe and appropriate patient care (Kilminster *et al.,* 2007, p.3).

This definition recognises that benefit can be derived from analysing and learning from errors. Educational supervision is a core component of postgraduate training in psychiatry in Ireland, scheduled to occur one to one between a trainee and their supervisor for one hour per week, and it is in this protected time that analysing cases

and learning from errors should occur. Empirical evidence shows that the quality of the supervisory relationship strongly affects the effectiveness of supervision, and that good interpersonal skills and high emotional intelligence are qualities that good supervisors need (Kilminster *et al*., 2007).

Kilminster *et al.* (2007) agree that supervisors need training and guidance, particularly in areas such as feedback giving, counselling skills and interpersonal skills. I believe that implementation of this guide for would impact positively by helping supervisors confidently negotiate a difficult time with their trainees, and more broadly may influence the thought they put into their role as a supervisor, enhancing their skills. Their awareness of the problem will also be raised through their involvement in the programme as well as the dissemination of the results.

Trainees would be impacted positively, in the event of a patient suicide by both they and their supervisor being prepared, and also more globally through positive role modelling on the part of their consultant.

Finally, the CPsychI could be impacted in several ways. There are difficulties at present recruiting and more importantly retaining trainees in psychiatry. This initiative could lead to improved rates of retention and possibly fewer days lost through absenteeism and sick leave. Designing, evaluating and publishing an educational innovation can also

bolster the reputation of the relatively young organisation as educators, and academically, as well as enhancing the research ethos of the organisation.

5.2.2 Practice

As discussed in the introduction and literature review, the present state in terms of providing support for trainees following a patient suicide is *ad hoc* and not always helpful. While my vision for the future may not impact on every supervisors practice, I am certain it can result in a positive change for the significant minority of trainees who need better support. Even if unsuccessful, I believe raising awareness of the current problem will result in improved practice.

5.2.3 Theory

The model proposed, whereby a trainee is prepared and supported individually by their supervisor, mediated by a guide, has not been researched to date. The responsive, qualitative component of the evaluation plan will facilitate generation of hypotheses for further research. This model, if found to be useful, could also have a profound impact for trainees in many disciplines for reasons of adaptability, discussed in the next section.

5.3 Strengths of the Project

The principal strength of my proposed programme is the potential for adaptation for use in other disciplines. Trainees in mental health nursing, psychology, occupational therapy, social work, and general practice experience difficulties when they lose patients to suicide. In each area trainees are assigned mentors, tutors or supervisors who could use guidance, perhaps more so than supervisors in psychiatry.

The “Pick any Two” model for project management, illustrated in Figure 6, reflects the concept that three properties of any project are interrelated, and that in most cases one of the three suffers at the expense of the other two. In my plan, cost is not a significant issue, there is no urgency in completing the research, and so the quality of evaluation can be of the highest standard.

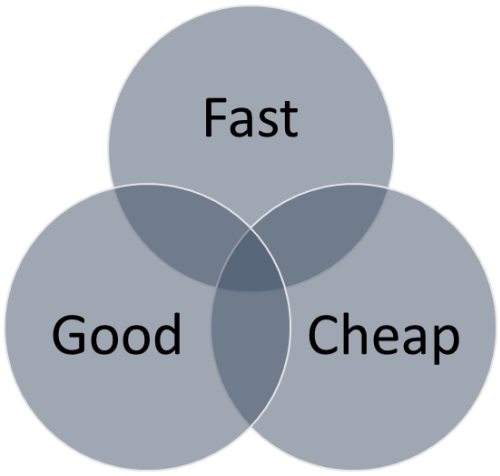

Fig 6 – Pick any two

Likewise, the “Triple constraints in Project Management” theory (Fig. 7), illustrates how quality is affected by constraints of time, cost, and scope. The limited cost and lack of urgency can allow significant scope for refinement and development of the model.

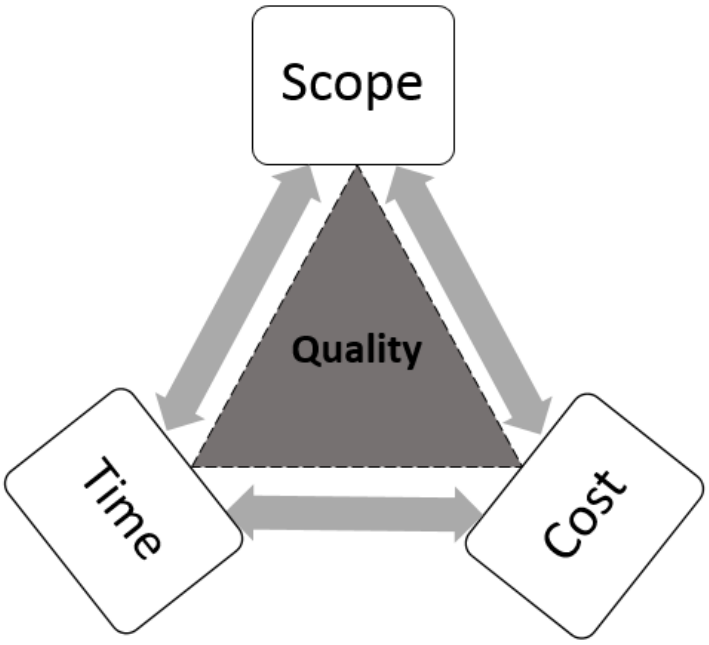

Fig 7 – Triple constraints of project management

5.4 Limitations of the Project

The limitations, strengths, potential problems and opportunities are summarised in a SWOT analysis in Appendix D. The principal limitation at present is the absence of concrete support from those in positions of power in the CPsychI. Further limitations may emerge as the programme plan progresses as proposed, however, they may be irrelevant if the plan goes no further without buy-in from the key stakeholders.

Another limitation is the absence of ethical approval to proceed with my programme plan. In the absence of a requirement for ethical approval, and the possibility of change to my plan prior to implementation, I did not apply a framework to comprehensively consider all ethical considerations. When approval is required and further consideration is given to the ethical issues, unforeseen issues are likely to emerge (Strutchbury & Fox, 2009).

5.5 Recommendations

I look forward to pressing on with recruitment of support and preparation to implement this project in the near future. There are several items that I can see facilitating the guide being successfully implemented. Firstly, allowing the time to complete a broad evaluation using Stake's model as outlined in chapter four, which gathers quality information and value judgements from multiple perspectives, will be crucial to refining the model and the eventual success of the programme. Next, that evaluation during the first year will inform whether supervisors will need training in the use of the model. I do not foresee this being an issue, though it will need consideration. I believe that recruitment of an external expert in evaluating similar educational programmes, prior to cycle three, could enhance the chances of success. Finally, I would recommend keeping in mind the need for short, medium, and long term wins, as this three year plan will need momentum to be maintained throughout to give a high chance of success.

5.6 Learning about Organisational Development

When proposing this project I felt confident that the merit in the project, the potential for profound benefit, would ensure it's success. Through study of organisational change management I have come to realise the complexity in bringing about change in any organisation. Of particular value was learning through application of the OD model, along with other tools discussed in the text. Forcefield analysis (Appendix E), and especially stakeholder analysis, are tools I will use alongside a change model for the smallest changes I will consider making in my future practice. Whether I do consider taking on organisational development may depend on the success or otherwise of this plan, as failure may leave me feeling loathe to commit to future change management, while success may be an addictive positive feedback.

If I were to begin this project again I would do one thing differently, to look for concrete support and assistance at an early stage. Having put so much into the project I will work hard to ensure it is implemented, however I know this dissertation would read very differently had I enlisted formal buy-in from a supporter at an early stage. It has also highlighted to me the value of team cohesion in sharing burdens and maintaining momentum to bringing about change.

5.7 Summary and Conclusion

In this chapter I have outlined the strengths and weaknesses of my project, particularly in relation to the planning process. I have considered how it may impact on key

stakeholder groups, and made recommendations for the future to improve the chances of success. Finally, I brought attention to some issues regarding my learning about planning for change.

I believe there is a need for development in this area, and that I have constructed a robust plan for development and implementation of an educational programme that can meet that need. I am aware of one major problem in this plan, the absence of key stakeholder buy-in. I am also conscious of the possibility of unforeseen challenges arising as the change proceeds, but am confident that the merit of my aim can overcome these obstacles.

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Appendices

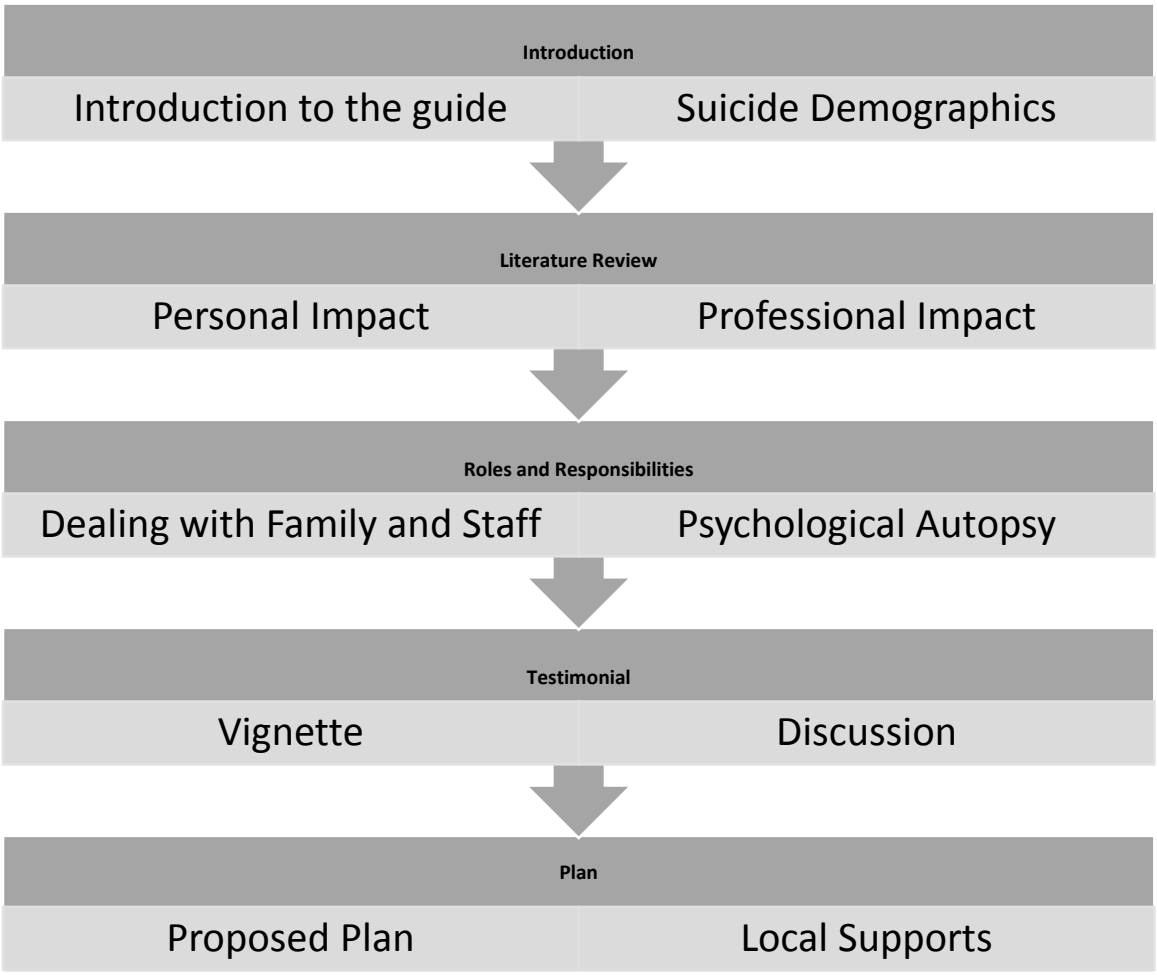
Appendix A – Gantt Chart

Student Name	Finbar McCarthy	Student ID	13122461

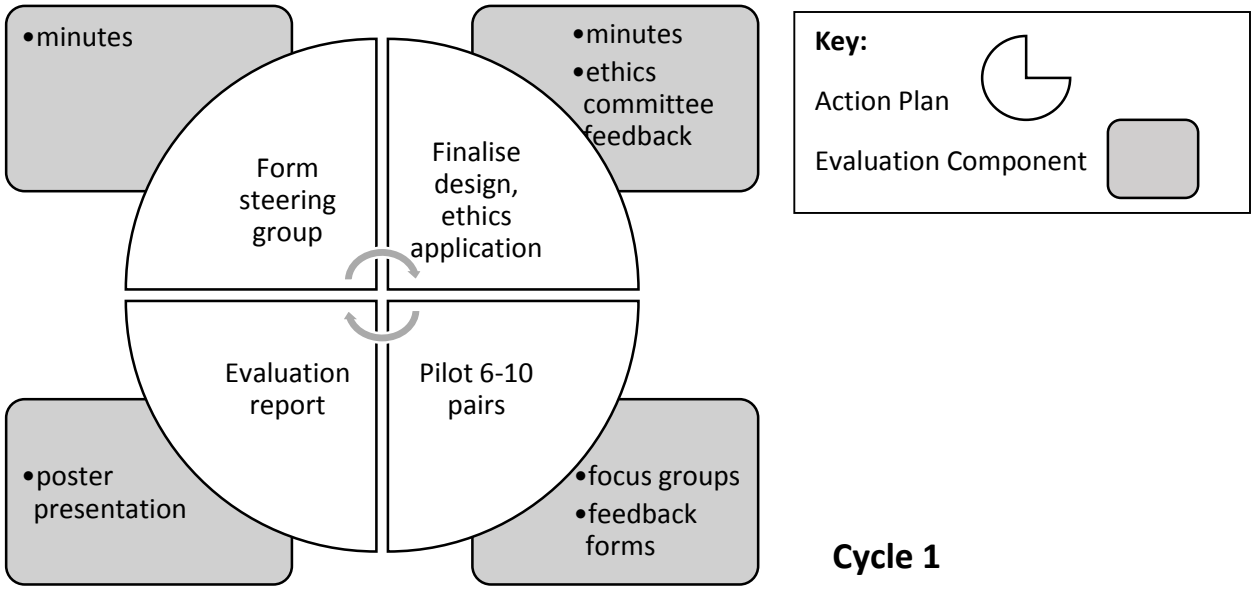
Mini Gantt Chart

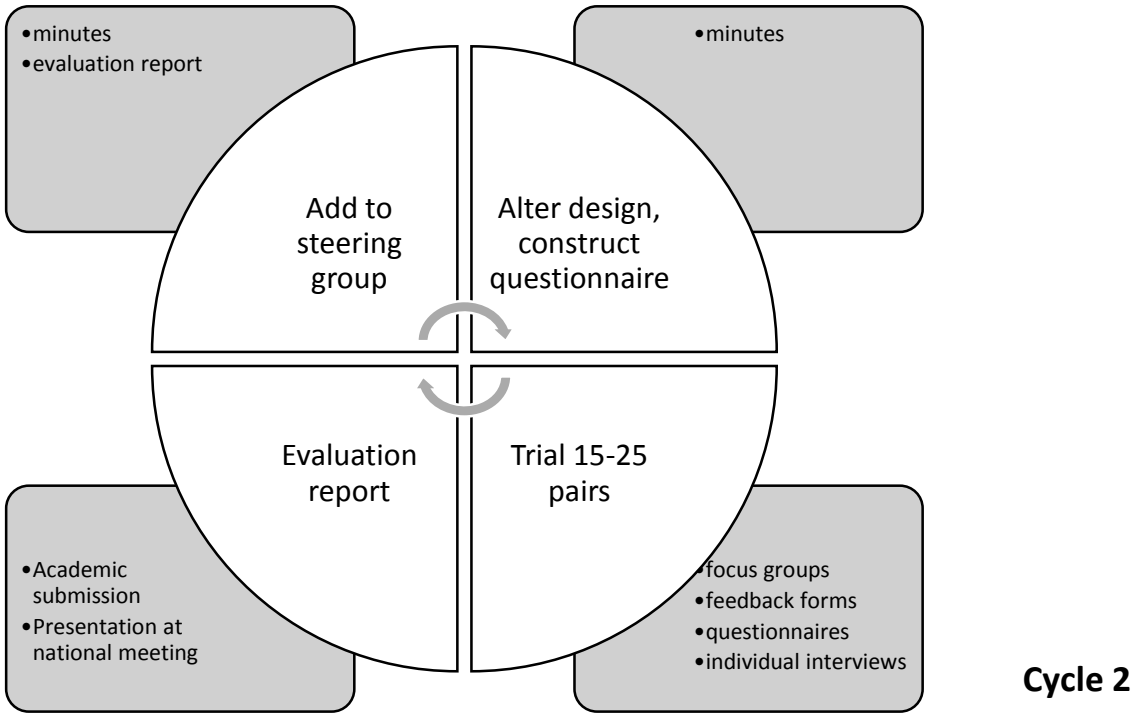
Project Steps / Phases	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May
Project proposal/Planning									
Seeking organizational support									
Literature Review									
Formulation of guideline									
Write up study									
Submit Dissertation									x

Appendix B – Guide Contents

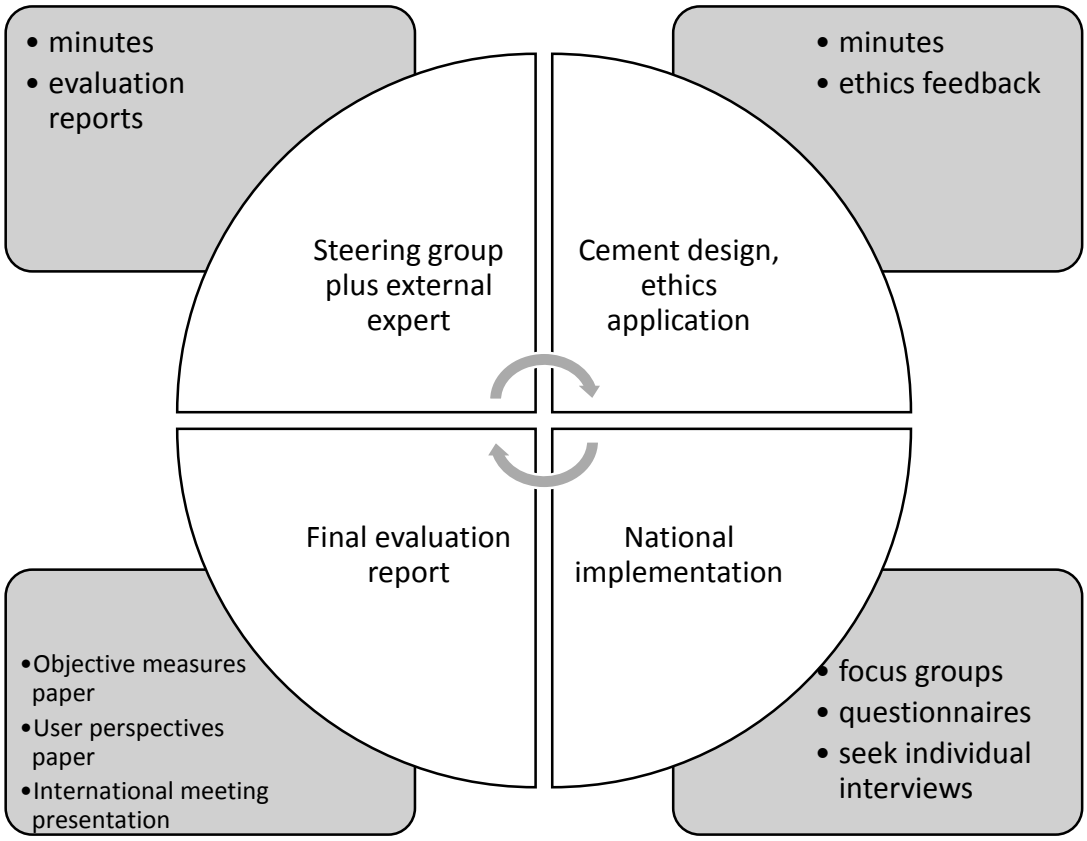


Appendix C – Action Plan





Appedix C – Action Plan



Cycle 3

Appendix D – SWOT Analysis

Strengths	Weakness
• Widely recognised and called for need for training programmes • Built in evaluation • Educational supervision a component of the curriculum • Supervisors already competent in dealing with sensitive issues • Agreement from Training Committee of need, and to discuss further • Low financial cost	• Lack of definite support • Ethical approval not secured • Training curriculum already busy and demanding • Training curriculum competency based – poor fit • Plan does not include training for supervisors
Threats	**Opportunities**
• Reluctance to change among supervisors, to lose autonomy • Emotive issue, possibility of causing offence to unidentified party • Costs – manpower requirement for latter stages of evaluation • Rejection of ethical approval	• Enhance reputation of the CPsychI for prospective trainees • Enhance reputation of CPsychI as leader in professionalism and academic psychiatry • Development of supervision guide for use in other disciplines • Financial case – less sick leave and greater retention of trainees

Appendix E – Forcefield Analysis

Drivers	Resisters
• Trainee recruitment and retention problems • Academic zeitgeist and momentum • New organisation seeking to build academic excellence • Motivation of change agent +/- opinion leaders • Financial Case	• Reluctance to change • Cost • Workload • Established practices and customs • Trainees existing workload